

University of Alberta

Becoming a Peer Health Educator: Case Studies

by
Genevieve Jones



A thesis submitted to the Faculty of Graduate Studies and Research in partial
fulfilment of the requirements for the degree of Master of Science

Centre for Health Promotion Studies

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Abstract

Huddersfield, United Kingdom, is an ethnically diverse community in northern England. In an effort to reduce high levels of ill health experienced by ethnic minority communities, the Peer Health Education Programme (PHEP) was initiated. PHEP provides salaried positions to existing natural helpers and trains these individuals to support their peers in the areas of heart health and post-natal health.

Using a multiple case study approach, this study explores the experience of transformation from natural helper to paraprofessional lay health advisor. The results indicate that, with one exception, PHEs have had a positive journey, gaining knowledge, self-confidence, and self-efficacy, in spite of an undefined role and varying support from health professionals. They have more defined life goals and feel confident that these goals are attainable. Although they can identify social and political structures in the community, they do not yet apply this knowledge to their work, believing that ill health is related to lack of knowledge.

Acknowledgements

While my name is listed as the author of this document, this research represents the support and participation of a large number of people. The usual joys and struggles of thesis research were compounded, in my case, by two additional elements: physical distance, both from my thesis committee and from the subjects of my research, and by combining an academic life with an active career. Without the enthusiastic support and cooperation from all who were involved in this project, I would not have been able to complete this work. It is therefore with gratitude that I acknowledge the contribution of the following people:

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The staff of the Huddersfield Healthy Living Initiative and the Huddersfield Health Promotion Unit (Huddersfield National Health Service (NHS) Trust) who allowed

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CHAPTER 1

INTRODUCTION

Imagine the following scenario: You have recently arrived in a new country. In addition to learning a new language and trying to find a way to financially support your family, you have to learn to navigate a new health care system, one that is very different from that which you experienced in your country of origin. You know that some of your “tried and true” health remedies that you practiced for years back home are not respected in this new country, and some of what you are being told by your health care practitioner goes against what you have always practiced.

That is only one example of the situation experienced by many new arrivals, and even second- and third-generation immigrants, in England. These communities can be challenging for health care professionals, who are mostly White British, to reach. These so-called “hard-to-reach” communities are often so labelled because they are hard for health professionals to access, communicate with, and therefore provide meaningful and effective health services (Eng, Parker, & Harlan, 1997).

One method of reaching out to the hard-to-reach communities is to use members of these communities to deliver health information to their peers. These members are known by many names—lay health advisors, village health workers, peer health educators—but the approach is the same. The lay health advisor approach identifies natural leaders within the target communities, provides them with some form of training and sometimes a form of remuneration, and counts on them to use their knowledge of and status within their community to promote health messages and encourage mobilization in ways that health professionals outside the community often cannot. Although these

methods have likely been used throughout history in one form or another, the formal usage of these methods in health care gained popularity in the late 1970s (Service & Salber, 1979). Since that time the lay health advisor approach has increased in popularity and has been successfully employed with an almost countless array of health interventions. Promoting sexual health (Blumenthal, Eng, & Thomas, 1999) and general access to health information (Hale, Bennett, Oslos, Cochran, & Burton, 1997), encouraging dietary change (Bird, Otero-Sabogal, Ha, & McPhee, 1996), facilitating smoking cessation (Lacey, Tukes, Manfredi, & Warnecke, 1991), and improving uptake of prenatal services (Meister, Warrick, deZapien, & Wood, 1992) are just a few of the many examples in the literature.

Although the effectiveness of the lay health advisor approach to target populations has been demonstrated, one essential element is often absent from these studies: the effect of participation in these programmes on the lay health advisors themselves. Selected researchers have explored initial motivations for lay health advisors (Ramirez-Valles, 2001) and have looked at changes in empowerment as a result of participating as a lay health advisor (Booker, Robinson, Kay, Najera, & Stewart, 1997). In all of the studies that focus on lay health advisors, there is the hint that transformation occurs: the transformation from lay person to paraprofessional. However, this transformation has never been studied.

The Peer Health Education Programme (PHEP) is one component of a comprehensive regeneration project in Huddersfield, West Yorkshire, United Kingdom. The Huddersfield Healthy Living Initiative (HHLI) is a project funded by Single Regeneration Budget Funding (SRB), and it is designed to increase opportunities for

healthy living in the most deprived areas of Huddersfield. Initiatives funded by SRB are intended to reduce inequalities between deprived areas and advantaged communities, as well as between different groups of people. Launched in 1994, the SRB is the result of an amalgamation of a number of programmes from several British government departments, intended to simplify the process with the aim of simplifying and streamlining the assistance available for regeneration. One of the hallmarks of SRB funding is that it is administered by local regeneration partnerships and carried out by local people. The main focus of the HHLI is to reduce the inequalities that lead to ill health (Office of the Deputy Prime Minister, n.d.).

The overall aim of PHEP is to help individuals within the ethnic minority communities in Huddersfield take control over their lives and health. The Peer Health Educators (PHEs) encourage this process within their community by facilitating education, empowerment, participation, and advocacy relating prioritised health topics (in this case, heart health and postnatal health). Through the activities, the PHEs increase the control that individuals have over their personal health and eventually influence more positive health outcomes for Asian and African-Caribbean communities in Huddersfield. Planning for PHEP began in April 1999; the team of PHEs was recruited in February 2000 and began work in April 2000.

Huddersfield, located in West Yorkshire, is the largest town in England, with a total population of 373,400 (including outlying areas). Huddersfield was a thriving textile and industrial centre until the mid-1950s but needed to economically reinvent itself because of a changing global economy. Huddersfield has always been innovative and in 1998 was named among the most innovative European cities. In spite of this,

Huddersfield scores high on indexes that measure levels of deprivation and demonstrates a gap between deprived and advantaged communities. In 1995 a large programme of regeneration began, funded in part by SRB monies. Current and past regeneration involves investment of over 224 million pounds. Funds are managed by Huddersfield Pride Ltd., an organisation that was set up to administer the wealth of regeneration funding that has been awarded to Huddersfield since 1995. Over the years, funding has been used to increase safety and reduce crime, promote business generation and generate jobs, increase educational opportunities, regenerate the town centre, improve and restore buildings, support healthy living, improve quality of life, and build community capacity. Current projects are ongoing until at least 2006 (Huddersfield Pride Ltd., n.d.).

Huddersfield has a significant ethnic minority population that is concentrated within five districts (Table 1). On average, these areas have a Jarman Score of 30.79 and an average minority ethnic population of 21.62% (Haynes & Johnson, 1998). The Jarman Score is a recognised way of identifying an area's deprivation and health care needs. It identifies a range of socioeconomic characteristics that are associated with high death rates and illness. Data included in the score are population size, lone pensioners, children under 5, lone-parent households, unskilled workers' unemployment rates, overcrowding, ethnicity, and population migration (Jarman, 1983). The ethnic minority composition of Huddersfield is largely of Pakistani origin, with the second largest group of African-Caribbean origin (Table 2). In Huddersfield, ethnic minority communities experience higher levels of social deprivation and more ill health than do the dominant social groups. Although there are many reasons for higher levels of ill health, one major hypothesis

suggests that a lack of empowerment and control is a major contributor to ill health in these populations (Kirklees Race Equality Council [KREC], 2000).

Table 1

Target Areas for Peer Health Education Programme in Huddersfield

Geographical ward	Jarman Score	Minority ethnic (%)
Birkby	24.00	33.06
Crosland Moor	26.94	22.08
Deighton	43.48	20.49
Newsome	34.75	15.46
Paddock	24.80	17.00

Adapted from: Haynes & Johnson (1998, App. 14).

Table 2

Minority Ethnic Population in Huddersfield

Ethnic Origin	Number	Percentage (%)
Pakistani	17,500	4.7
Indian	11,900	3.2
Bangladeshi	400	0.1
South Asian other	1,100	0.3
Black Caribbean	4,500	1.2
Black African	400	0.1
Black other	1,800	0.5
Chinese	400	0.1
White	333,200	89.3
Other groups	2,200	0.6
TOTAL	373,400	100.0

Source: Census of Population (1991).

Question

Based on the literature, the potential of lay health advising programmes to positively affect the lay health advisors themselves is evident. This study explored the experience of participation in the Huddersfield PHEP on the PHEs themselves. The key element of the experience research was the transformation from natural helper to paraprofessional. One of the criteria for recruitment of the PHEs was that they needed to be a natural helper; that is, already engaged in their community and respected by their peers. This quality was ascertained through a selection interview process. In other words, all PHEs were already natural helpers in their respective communities. Their journey and transformation consist, in part, of becoming paraprofessionals and being paid for what they were doing previously as a member of a community and currently as an employee of an agency.

The research question for the study was:

What is the lived experience of the transformation from a lay natural helper to a paraprofessional lay health advisor?

Components of this transformation were clarified through the following subquestions:

1. What were the participants' initial motivations and expectations for joining the PHEP? Each PHE joined the programme for a reason. In some cases these reasons will have materialized into reality; in others the reality may be quite different from expectations. As well, the agency also had expectations of the PHEs. The relationship between their initial motivations and expectations and the reality that they

experience in meeting the agency's expectations may have an effect on personal experiences in becoming a PHE.

2. What are the participants' reflections on training? The intensive 14-week training programme that the PHEs attended was their first activity as PHEs, and thus presented their first potentially transformative experience. Each PHE documented his or her reflections in a journal at the end of each training session and handed the journals in to the Peer Health Education Coordinator.

3. What are the participants' personal perceptions of the effect of the experience of working as PHEs? These perceptions were explored through the following questions: What effect do they feel the programme has had on their role within the community, and what effect do they feel the programme has had on themselves? The PHEs were requested to describe positive and negative aspects of their experiences.

4. What was the participants' experience of contact with health care staff? PHEs have occasion to work with health care staff on a regular basis. They were asked to describe the quality of this interaction and whether or not it led to a feeling of support of peer health education and of PHEs themselves.

5. What is the participants' level of empowerment? PHEs were asked to describe how empowered they felt from the beginning of the programme to the time of the interview; that is, their perceived degree of control over their life and work, their perceived level of self-esteem, and the degree of influence that they feel they have within the community.

Personal Beliefs and Assumptions

When selecting a thesis topic, I was advised to select a topic that I would find interesting. I decided that the topic of lay health advising interested me most. Beyond being a subject that I find fascinating, it is also a subject with which I have a great deal of personal experience. In order that the reader may have an understanding of my personal beliefs and assumptions on this topic, I have included this section.

In 1999 personnel from the Huddersfield NHS Trust ("the Trust") Health Promotion Unit wrote a proposal to include, as part of a large health regeneration project, a lay health advising programme in an effort to improve the health of the South Asian and African-Caribbean populations in Huddersfield. The proposal was accepted for funding, and a coordinator was sought. I responded to the advertisement in the *Guardian*, a British newspaper, and was selected for the job. As the coordinator of the Huddersfield Peer Health Education Programme from April 2000 to May 2001, I played a significant role in shaping the project. From the concept that was written into the original bid for funding, I finalized the concept and developed the plan for the programme, as well as training programmes and work opportunities for the PHEs. In January 2001 I recruited the team of 10 PHEs and coordinated the team from April to May 2001. I left, reluctantly, for personal reasons in May 2001. When I left the programme, the PHEs were approximately one third finished their 14-week training programme. Since I left the programme, I have had no formal contact with the programme and only intermittent light social interaction with some staff members of the Huddersfield NHS Trust Health Promotion Unit.

My journey in lay health advising does not start and end there. In September 1992, on the morning that I arrived at Lister Hall Residence at the University of Alberta, I

saw an advertisement for the University of Alberta Peer Health Education Program, a programme specializing in peer-to-peer information on sexuality, alcohol, sexual assault, and eating disorders. As soon as I saw the display table, I knew it was the job for me. I was a PHE from September 1993 to April 1996, playing various coordinating and hands-on roles over the years. Being a PHE was perhaps one of the best experiences of my life: I learned, I taught, I formed a vast and extremely supportive network of friends and colleagues, and I experienced an enormous feeling of self-confidence. Was it all due to peer health education? Probably not; likely it was one factor among many at the time, but it was still a significant factor.

Participating in the PHEP, however, literally changed my course in life. Instead of following an anticipated career in medicine, I have pursued a career in health promotion. Why? Because I experienced firsthand the power of affecting health by reducing some of the inequalities that lead to ill health and the power that social networks play in influencing health-related behaviours. Every day I continue to use the skills that I learned as a PHE.

My experience as a PHE is unique. Very few of my colleagues experienced the degree of effect that I did. Some stayed with the programme a few months, some for years. Anecdotally, about a quarter of us changed our career plans to include more of a focus on health promotion or social justice. Others maintain that it was a great experience, but nontransformative.

My personal opinion of peer health education is that it is an instrument of incredible potential, but its effect on PHEs themselves will vary significantly. Although it is something that I support personally, I fully recognize the limitations of the method:

Among other things, I realize that it is not "everyone's cup of tea"; nor is it always the best method to encourage behaviour change in everyone. However, it is one method that, in my opinion, can work in harmony with other methods (such as community development approaches) in a complete health promotion programme.

Of course, I come to this study with certain assumptions about how the PHEs might respond to each part of the study. Regarding their motivations, I believe that some were motivated in part by the fact that this is a job that pays well, and not necessarily because of the type of work. In all cases, however, I think that it is combined with a genuine interest in serving their community and a commitment to the principles of community development. From what I saw in the training, there was an increase in empowerment for almost all of the PHEs. Anecdotally, we had a range of "starting levels" of empowerment in the group; yet by the fifth week of the training there seemed to be more uniformity in the level of empowerment. During training (or the parts for which I was present), the PHEs were particularly struck by determinants of health, and that seemed to be a big turning point for some. Regarding the process of movement from natural helper to paraprofessional, I think that some of the PHEs will feel frustrated by the constraints, the administrative paperwork, and the general (comparative) bureaucracy of working in an organization. However, some of the PHEs, I suspect, will feel more validated and supported in their work through the Trust.

Significance of the Research

Lay health advisor programme interventions have been, and continue to be, a popular method of health promotion. Although relatively inexpensive, they have been shown to be an effective way of influencing health beliefs and behaviours through social

networks (Eng & Young, 1992). In England the popularity of lay health advisor interventions is well established and continues to increase as the British Labour government puts greater emphasis on health promotion and disease prevention strategies. In Canada lay health advisor interventions are popular in universities and are also used in conjunction with breast cancer screening programmes in Alberta and Ontario. Regardless of where a programme is located or what the focus of the programme is, lay health advisor programmes rely on the availability of natural helpers who are willing to turn their natural skills into paraprofessional assets. Although most natural helpers are probably not adverse to being paid for something that they do naturally, there is a process of transformation that lay health advisors undergo as they enter the world of paraprofessionals. The more that is known about this process, the more effectively this transition can be articulated, planned for, and maintained.

The majority of research related to lay health advisors indicates positive outcomes for the lay health advisors, but there is also a body of research that indicated that lay health advisor programmes may have negative consequences for natural helpers. In exploring the experiences of the PHEs, this study will further inform the literature on the positive and negative effects of lay health advising programmes on their staff.

CHAPTER 2

REVIEW OF THE LITERATURE

Lay Health Advising: What's That?

The question that most frequently follows the use of the term *lay health advising* is "What's that?" Lay health advising is a term that encompasses many definitions. For the purpose of this study, lay health advising is considered to embrace both natural helping and paraprofessional helping.

Helping exists on a spectrum from informal to formal. On one end of the spectrum are natural helpers: individuals to whom others naturally turn for help and support. Natural helpers are an informal source of support who are internal to their community (Eng & Young, 1992). They are neither paid nor engaged by an agency; they are simply individuals who are known to have good judgement, offer sound advice and a caring ear, and exercise discretion (Eng et al., 1997). Their role is often so much a part of their lives that natural helpers may not even recognise their role themselves (Israel, 1985). At the other end of the spectrum of natural helping is paraprofessional helping (see Figure 1). In this capacity, lay health advisors are formally linked with a health care service provider or other agency and offer an extension of the agency's services. These individuals are recruited according to formal criteria, paid, and often undergo a certain training period, after which they need to demonstrate a certain level of competence (Eng et al., 1997).

Natural helping

Paraprofessional helping

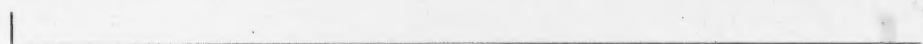


Figure 1. Continuum of lay health advisor helping (Eng et al., 1997).

There are advantages and disadvantages to each type of lay health advising.

Natural helpers are community based and are completely responsible to the community which they serve. Because they are informal and partisan to their community, they can respond quickly and without prejudice to the immediate needs that are presented to them. One disadvantage of natural helping is that there is no control over the type and quality of informational support that is offered. A natural helper may instigate or reinforce myths within their community. On the other end of the spectrum, paraprofessional lay health advisors undergo standardized training and usually have a mechanism of quality assurance through their links with an agency. Because paraprofessional lay health advisors are paid, they also gain the advantage of a salary and the potential for career advancement (Eng et al., 1997). In training lay people, professional knowledge and techniques are shared in the context of empowering them (Beam & Tessaro, 1994). For the agencies involved, paraprofessional lay health advisors provide a mechanism for effective community outreach; conversely, the community benefits because paraprofessional lay health advisors are able to effect change within the system so that it can better meet the needs of the community (Beam & Tessaro, 1994). A disadvantage to paraprofessional lay health advising is that the lay health advisors are partisan to an agency. Depending on the level of influence that the agency exerts on the lay health advisors, the lay health advisors must conform (to a greater or lesser extent) their lay

helping to the agencies' priorities. These priorities may or may not reflect the priorities of the communities.

The lay health advisors themselves are central to the lay health advising programme; therefore the recruitment process is key to the success of these types of programmes. One documented criticism of lay health advising programmes alleges that attempts to formalize a natural helping process may "undermine the strengths" and change the naturally occurring helping network (Israel, 1985). The literature indicated that personnel for lay health advising programmes are recruited in a variety of ways: Some use traditional recruitment methods that involve applications and interviews, but most rely on the community itself to identify individuals who they think would be suitable for the role (known as *reputational recruitment*). Regardless of the method of recruitment that is used, the common characteristics sought by recruiters involve a sharing of the target population's language, religious beliefs, social characteristics, and ethnic characteristics (Earp et al., 1997); respect by the target community; active social networks within this community; and philosophy, skills, and goals that match with broad programme goals (Schultz, Israel, Becker, & Hollis, 1997).

The majority of lay health advising programmes identified in the literature use reputational recruitment methods (Earp et al., 1997; Giblin, 1989; McFarlane & Fehir, 1994; Parker, Schulz, Israel, & Hollis, 1998; Tessaro et al., 2000). Reputational recruitment is the model described by Service and Salber (1979), which involves identifying individuals through key agencies and community groups, people in key occupations who are respected by the target community, outreach workers in the target area, lay health advisors programme coordinators who are familiar with the target area,

previously trained lay health advisors, and community residents. These identified individuals are thought to embody the accepted norms and identifying characteristics of the target community, including language, ethnicity, geographic location, social network, and culture. Self-identification of lay health advisors can also be used as long as other community members confirm that these individuals are, in fact, considered to be natural helpers by the target community. Using reputational recruitment is one method that seeks to ensure recruitment of "true" natural helpers versus individuals who merely serve as connectors between the health care service and health care providers (Beam & Tessaro, 1994). Although it is upheld as the "ideal," reputational recruitment is not always feasible for recruiting agency-based staff in an agency with formal recruitment methods.

Mechanism of Lay Health Advising

The mechanism of lay health advising is a rather complicated one that is built on the simple concepts of social support and information giving, related to health. It is generally accepted that lay health advisors offer four types of social support:

1. emotional support: listening, showing trust and concern
2. instrumental support: offering tangible aid in terms of time and resources
3. informational support: providing information, advice, and referrals
4. appraisal support: giving affirmation and feedback (Beam & Tessaro, 1994; House, 1981).

In any particular lay health advisor intervention, the type(s) of support that lay health advisors offer is determined by the nature of the relationship they have with a particular client and the needs of that client. In every case these interventions can work at the individual and/or social and/or community level (Figure 2). Whether the intervention is at

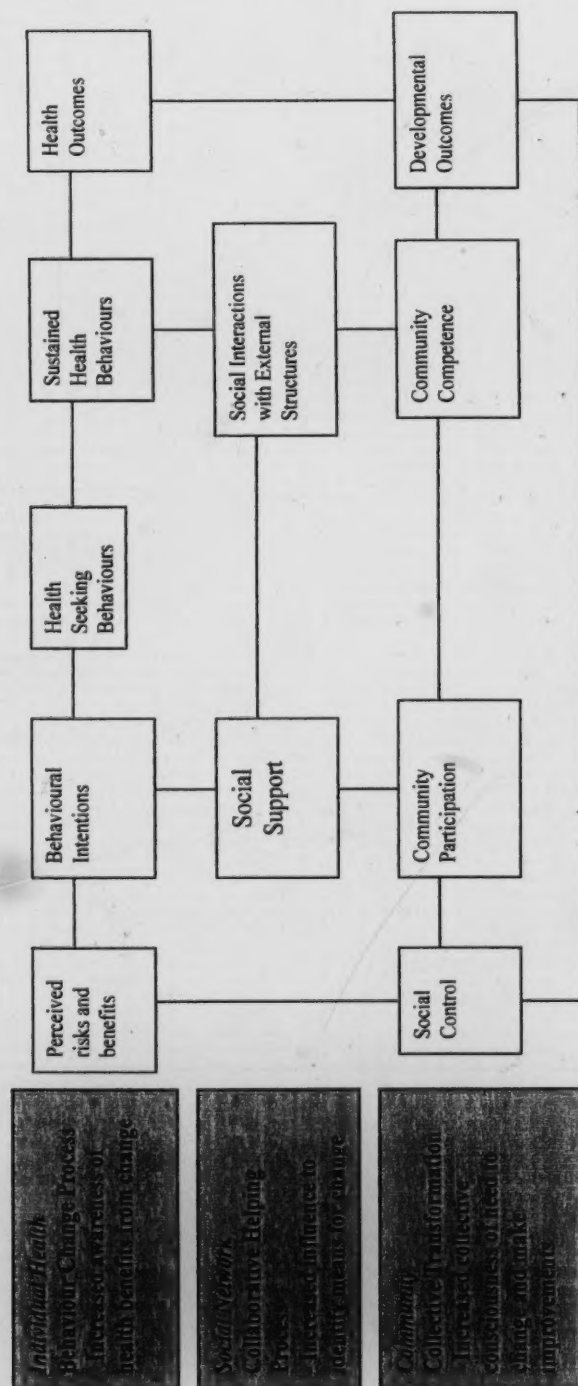


Figure 2. The Lay Health Advisor Model (Beam and Tessaro, 1994).

the individual or community level, the social support offered by lay health advisors is seen to be the key factor that encourages change: on the individual level, influencing behavioural intentions and sustaining these behaviours; and on the community level, both encouraging participation in the community and building the capacity of the community. At its heart, the lay health advisor model is a model that builds on the strength that exists within the community by working with the influence of naturally existing social and community support.

In addition to its effect on the community, participating as a lay health advisor is thought to have an influence on the lay health advisors themselves. A study by Schulz et al. (1997) examined the experience of lay health advising from the perspective of the lay advisors. The study examined their definitions of helping, their conceptualisations of their role, the qualities they believe are important to their work, the perceptions of their relationship in the community, and the tensions as well as the rewards encountered in their roles as both community members and lay health advisors. Schulz et al. acknowledged that, over time, participants developed an identity as lay health advisors, shaped by their experiences in the project. The authors underscored the health supporting mechanism of social support, indicating that lay health advising programmes may have a health-protective effect. The lay health advisors were not alone in experiencing this support; reciprocal support was experienced by lay health advisors, community members, the project coordinator, and supporting institutions. Regarding empowerment, the lay health advisors reported working at all four levels of support described by Eng and Young (1992) in their lay health advisor model, and they reported changes at the levels of the individual, the organization, and the community. Schultz et al. felt that these changes

are consistent with the dimensions of community empowerment, underscoring the role that lay health advisors play in community empowerment by "strengthening the ability of community members to work through existing social networks to influence political, social, and economic processes related to health" (p.477).

Empowerment

One of the key mechanisms by which lay health advisor programmes are said to work is by providing opportunities for empowerment at both the level of the lay health workers themselves and the level of the communities in which they work. Empowerment is a fundamental health promotion concept, yet arguably one of the concepts that is the most elusive and most difficult to define. Depending on the author and the context, even the definition of empowerment differs (Ellis-Stoll & Popkess-Vawter, 1998).

Empowerment exists on a spectrum. At one end of the spectrum is personal or psychological empowerment. At the other end of the spectrum is collective empowerment. Collective empowerment is a social action process in which community members (individuals and groups) both control and have access to resources and ensure that the needs of the community are met (Schulz et al., 1997). Community empowerment captures the social context in which empowerment takes place (Wallerstein & Bernstein, 1994).

Another description of community empowerment is "an interactive process of change, where institutions and communities become transformed as people who participate in changing them become transformed" (Wallerstein & Bernstein, 1994, p. 142). Mere participation by individuals was often cited in the literature as a key to creating empowerment.

The overarching consensus in current health promotion literature is that community empowerment is the most noble goal of health promotion because an empowered community holds within itself the power to change oppressive structures. However, it is important to remember that the roots of community empowerment lie in individual empowerment: If the individuals who make up the community are not empowered, the community cannot be empowered. Ira Shor and Paulo Freire (1987), the noted Brazilian educator, made a very profound statement on the relationship between individual and community empowerment:

Even when you individually feel yourself most free, if this feeling is not a social feeling, if you are not able to use your recent freedom to help others be free by transforming the totality of society, then you are exercising only an individualist attitude towards empowerment or freedom. . . . While individual empowerment, the feeling of being changed, is not enough concerning the transformation of the whole society, it is absolutely necessary for the process of social transformation. (p. 109-110)

In this quotation the authors recognized that communities are made up of individuals and that empowered individuals are at the root of empowered communities.

The mechanism of the effect of lay health advising programmes ideally works at three levels: the level of the lay health advisors themselves, the level of the target community, and the level of the coordinating agency.

Among the lay health advisor programmes that have been evaluated, some have focused, at least in part, on the effect of participation in the programme on the empowerment of lay health advisors themselves (Booker et al., 1997; Lugo, 1996; Schulz

et al., 1997; Stewart, 1990). Although the literature on empowerment is broad and proposed a number of definitions, the body of literature that explored empowerment in the context of lay health advising programmes took a particular view of empowerment: as a sense of control over one's life. Stewart (1990, whose work formed the basis for Booker et al., 1997) expanded beyond this definition of control and proposed a similar definition that focuses on individual empowerment, but recognises the social context of this empowerment. In her study of lay health advisors in a migrant farm-worker community, Stewart defined empowerment as "a sense of mastery over the environment through increased understanding of societal structures, resources, and factors which impact upon their lives and shape their response to their environment" (p. 4). She broke down this definition into critical components of personal and collective empowerment:

Critical components of personal empowerment:

- a. development of a sense of self-efficacy
- b. development of a positive social identity
- c. ability to transfer skills from one life domain to another

Critical components of community empowerment:

- a. knowledge of social and political structures of the community
- b. shift from victim blaming to structure blaming

Booker et al. (1997) expanded on these studies to look at the effects of participating in lay health advising programmes from the perspective of the lay health advisors. Although levels of gains in empowerment varied widely amongst the lay health advisors, a large majority of lay health advisors in this study felt empowered by their experience, measured using indicators of self-efficacy, a positive social identity,

knowledge of social and political structures connected to carrying out their roles, and the ability to transfer skills from one life domain to another. The findings of the study were consistent with over a decade of anecdotal observations of this particular lay health advising programme. The study built a conceptual model that recognizes the interdependence of the individual with his or her social environment. The lack of a comparison group in the study prevented the researchers from drawing the conclusion that participation in the programme was the sole reason for their increase in empowerment, recognizing that the programme was not the sole influence on the lives of the lay health advisors at that time. Interestingly, Booker et al. (1997) found that lay health advisors who demonstrated a high level of empowerment at the outset of the programme were those with higher levels of formal education and were more likely to be males—factors generally associated with high levels of empowerment. The researchers stressed that although changes in personal empowerment are difficult to measure, empowerment is an important programme benefit for lay health advisors.

To become paraprofessional lay health advisors, natural helpers generally undergo a process of transformation. There are relatively few studies that have documented this transformation, but the literature that is available on the subject highlighted increases in self-esteem, increases in status in their community, and/or changes in personal empowerment as a result of this transformation (Bellin, Killen, & Mageika, 1967; McCormick, Brooks-Gunn, Shorter, Holmes, Wallace, & Heagarty, 1989; McFarlane & Fehir, 1994; Westheimer, Cattell, Connell, Kaufman, & Swartz, 1970). Two studies have examined changes in empowerment as a result of participation in a lay health advising programme (Booker et al., 1997; Stewart, 1990). Both found positive increases, both

when the level of empowerment in participants was compared in a pre- and postintervention measure (Booker et al., 1997) and when programme participants were compared to programme nonparticipants (Stewart, 1990).

Because of the parallels between groups studied by Stewart (1990) and Booker et al. (1997) and the Peer Health Educators (PHEs), Stewart's components of empowerment were used to assess empowerment in the PHEs:

Critical components of personal empowerment:

- a. development of a sense of self-efficacy
- b. development of a positive social identity
- c. ability to transfer skills from one life domain to another

Critical components of community empowerment:

- a. knowledge of social and political structures of the community
- b. shift from victim-blaming to structure-blaming

Motivations of Lay Health Advisors

There is very limited literature about the initial motivations of natural helpers who join lay health advisors programmes. Jesus Ramirez-Valdes (2001) examined the initial motives for participating as a community health worker in Mexico. Overall, Ramirez-Valdes found that motives of the community health workers could be divided into four general categories: getting out (i.e., getting a break from normal routine), serving others, learning, and women's betterment (this particular programme concentrated on women's health). These motives, which are both self-oriented and other oriented, are consistent with the motives found in other studies on volunteer community participation (Ramirez-Valdes, 2001).

Setting and Context of Lay Health Advisors

In the literature there is limited research that explicitly discussed the context that supports the success of lay health advisor programmes. However, the setting can be inferred from the literature.

The vast majority of lay health advisors (83%) work within public health or social safety net programmes (Love, Gardner, & Legion, 1997). According to Love et al., this is probably due to the fact that these organizations are more likely to take an ecological, determinants-of-health approach that acknowledges the power of social support. Even within these supportive organizations, there can be internal barriers to lay health advising programmes.

The barrier most often mentioned is difficulties in lay health advisors' gaining acceptance from health professionals (Giblin, 1989; Jackson & Parks, 1997), illustrating that even though an agency may be willing to work with lay health advisors, health professionals may be reluctant to share elements of their role with a layperson.

Because lay health advising programmes generally have an empowerment focus, the willingness of the agency to further empower lay health advisors by actively involving them in defining programme goals (Giblin, 1989) and planning training programmes for other lay health advisors (Giblin, 1989; Jackson & Parks, 1997) can have an effect on programme outcomes.

Whether the lay health advisors themselves are paid or voluntary workers and the ability for a programme to financially support lay health advising programmes are also important. The lay health advisor programmes in the literature were all funded by grant money, whether one-time or recurring. This means that lay health advisor programmes

tread on very precarious ground, risking termination when resources are in short supply. In fact, lack of finances is the primary barrier to wider employment of lay health advisors (Love et al., 1997).

The Peer Health Education Programme

The Peer Health Education Programme (PHEP), at its heart, is designed to encourage empowerment and good health within ethnic minority communities in the most deprived areas of Huddersfield. The overall aim of PHEP is to help individuals within these ethnic minority communities take control over their lives and health. The PHEs encourage this process within their community by facilitating education, empowerment, participation, and advocacy relating to the programme topic areas. Through these activities, the PHEs increase the control that individuals have over their own health and eventually influence more positive health outcomes for Asian and African-Caribbean communities in Huddersfield.

A significant difference between the lay health advisors programmes cited in the literature and PHEP is that the lay health advisors programmes cited in the literature either relied on volunteers or paid lay health advisors a small stipend for their work. In contrast, PHEs are paid employees of the Huddersfield NHS Trust (the Trust). Therefore, to comply with the requirements of the Trust, a slightly different process of recruitment was used. Pure reputational recruitment strategies would have been viewed as unfair and inequitable by the Trust, which requires open competition for all jobs. Therefore, PHEs were recruited through an employment process.

A job description was created for the positions (Appendix A). The job was advertised in a variety of ways: newspaper advertisement, direct mailing to HHLI

supporters, and flyers. The distribution of flyers was combined with personal visits by the PHE coordinator. Throughout the development phase of PHEP, key community groups and members were both informed of developments and asked for their input, ensuring that engagement in the programme remained high.

A recruitment panel was assembled for the PHE recruitment process. The recruitment panel consisted of community representatives who also played a professional role in the community. The role of the recruitment panel was to confirm the suitability of candidates to work within the target community and to confirm the candidate's role as a natural helper within the target community. Using a recruitment panel provided an acceptable compromise between recruitment policies required by the Trust and the reputational recruitment method.

Almost 70 people applied to become PHEs. The applicants who most closely met the recruitment criteria were invited to a group interview at which their team-working skills were assessed. From this group the top candidates were invited to an individual interview. In this interview, their view of health and the extent of their social networks were assessed. From this group the top 10 individuals were invited to become PHEs. The proportion of South Asian/African-Caribbean/refugees who were eventually hired reflect the proportion in the Huddersfield ethnic minority community.

Although there were many priorities that could be addressed by the lay health approach, for the purpose of simplicity, two priority topic areas were selected for PHEP for the first year: heart health and postnatal health. As the PHEP develops and the PHEs further engage in their community, the priority topic areas of the programme can change as different community priorities are identified.

Heart Health Stream

In Huddersfield both Asian and African-Caribbean individuals suffer from significantly higher rates of coronary heart disease (CHD)-related deaths than do their White counterparts. They also have a higher tendency to central obesity and insulin resistance, which may predispose them to CHD and diabetes (Acheson, 1998). In the Asian population in Huddersfield especially, rates of CHD are twice as high as rates in the White population (University of Huddersfield, 1997). These high levels mean that any reduction in morbidity and mortality related to CHD will both improve quality of life for individuals and reduce the current burden on the health care system.

Supporting Expectant Parents and Parents of Young Children Stream

This stream aims both to improve access to quality postnatal care and parenting support and to indirectly combat the high feelings of social isolation and lack of social support that have been identified during consultation as a priority amongst women in ethnic minority communities in Huddersfield. This stream provides a forum for addressing more sensitive health issues such as family planning, drugs, and domestic violence, which are too sensitive to be overtly discussed in Huddersfield.

Each PHE concentrates on only one stream. The PHEs in both streams received both comprehensive training in health promotion approaches and specific information on the speciality area in which they work. Because each PHE works with a unique community segment, each has a unique relationship with his or her clients because the way of working is not prescribed. Instead, each PHE has an individual workplan and is encouraged to work in whatever way is most appropriate to relay messages to his or her particular community segment. The PHEs are strongly encouraged to use creative

approaches in their work. Some of the approaches already used include social theatre, presentations, and religion-based health discussions in the church or mosque.

CHAPTER 3

RESEARCH METHODOLOGY

Case Study

A *case study* is defined as an empirical inquiry that “investigates a contemporary phenomenon within its real life context; when the boundaries between phenomenon are not clearly evident” (Yin, 1994, p.13). Case studies are designed to be viewed in their ecological context (Bromley, 1986), meaning that experiences cannot be isolated from the environment (physical, sociological, and psychological) that shape them.

The boundaries of a case study inquiry are designed by the researcher (Munhall, 2001), who delineates the issue to be studied and the reference points from which this issue is to be studied. Therefore, the focus of a case study allows the investigator to concentrate on what is really happening within the defined boundaries and not on proving a predefined theory or hypothesis.

Case studies are a method of choice when there is little pre-existing data on a phenomenon of interest. Because of its emic approach (Morse & Field, 1995), the case study method allows for a holistic understanding of the phenomenon of interest. Because the case study is “grounded” (Munhall, 2001), it provides the reader with a perspective that evolves directly from the data and not from predetermined hypotheses or assumptions. Because of the small amount of pre-existing data and the fact that the Peer Health Education Programme (PHEP) is a multidimensional programme that lends itself to an emic study approach, case studies are an appropriate method of study.

There are, as with any method, limitations implicit to case study research. First of all, generalizability is the consideration of the reader of the study, in that a case study is

not usually representative of an entire population. Stake (1983), however, discussed a different perspective on generalizability and contended that case studies generate "naturalistic generalization," which comes from a recognition of similarities both in and out of context.

There are some unique ethical issues with case studies. The first types of ethical dilemmas in case studies result because the researcher has significant power in this type of research: shaping the data, bias, and nonreporting of contradictory data (Munhall, 2001). To avoid these pitfalls, one method is to triangulate data-collection techniques, use an external auditor, present findings to research subjects for verification, and ensure that all analysis is grounded in data.

There is also the risk that subjects will be identifiable by the data, because long quotations and descriptions are often used in case study research. Guba and Lincoln (1981) suggested that, before any particular quotation or detailed description is used, explicit approval be sought from the individual.

According to Munhall (2001), a case study consists of the following elements. I have described beside each element how this is being incorporated into the study:

- Identifying the purpose and questions of the study:
 - It is considered extremely important to limit the question being studied sufficiently so that the amount of data collected is manageable. By concentrating on one aspect of the Peer Health Educators' (PHEs') experience, the amount of data collected will be limited to that aspect. The type of question being asked is most appropriately guided by a case study approach.
- Identifying the theoretical propositions if appropriate to the type of case study being conducted:
 - There are no theoretical propositions that relate directly to this study. The outcomes of this study inform theory on the process of transformation of lay health advisors from natural helpers into paraprofessionals.
- Determining the unit of analysis:
 - The unit of analysis is the PHE, providing their perspectives on the question and subquestions being answered (see subject selection below).
- Developing the case study protocol:
 - The case study protocol includes a timeline and a draft interview protocol.
- Deciding on the most appropriate design:
 - A multiple-case design is a case study that draws on a number of cases. It is considered an appropriate choice when a researcher wants

to explore the same phenomenon with many individuals (Munhall, 2001). In contrast, single-case designs are used to illustrate either typical or atypical cases that are representative of a larger group. In this study the phenomenon as a whole is of interest, and thus the data will be viewed as a whole.

- Conducting the case study (collecting, analysing, and interpreting data):
 - In a case study the data collection can include a number of techniques to present both triangulation of data and a fuller picture of the phenomenon of interest. Ideally, the data should be gathered over time to provide the researcher time to develop a relationship with the group under study. Finally, a case study researcher should employ a “chain of evidence” (Munhall, 2001), which is akin to putting the researcher’s thought processes on paper. This increases both the transparency and the confirmability (by other researchers) of the data.
- Writing the case study report.

Munhall (2001) made it clear that it is essential for a researcher to clearly state his or her assumptions at the beginning of the study in order to effectively bracket these notions and ensure a thorough interpretation of the data that is not influenced by preconceived notions. My assumptions and story are detailed in the section entitled “Personal Beliefs and Assumptions.”

Validity is always a concern in qualitative analysis. Miles and Huberman (1994) proposed 12 strategies for increasing validity in qualitative research:

- *Checking for representativeness:* Representativeness of a study can be biased by preconceptions of the researcher or by the individuals who participate in the study. In this case the sample will consist of the entire team of PHEs; however, it must be borne in mind that they are not necessarily representative of the wider population. The researcher will make vigilant use of bracketing techniques to reduce the effect of preconceptions on the study.
- *Checking for researcher effects:* The presence of the researcher may alter the behaviour of the participants. This can be minimized by long-term observation, using unobtrusive methods, and using informants to avoid this effect. In the case of this study, because the researcher is already known to the PHEs, this may minimize researcher effects; but, on the other hand, this might also increase researcher effects if the PHEs feel that the researcher would “prefer” to hear a particular answer. This will be minimized by emphasising the desire to hear the truth, both positive and negative.
- *Triangulating:* Triangulating can improve validity. This will be accomplished by using both already-existing written journals and interview data.
- *Weighing the evidence:* Validity can be increased by reviewing the strength of the data to validate conclusions. This is done by critically analysing every piece of data to question why it should not be used.
- *Making contrasts/conclusions:* By comparing extreme data, the researcher must decide if the difference between extreme data is significant enough to be included in the analysis.

- *Using extreme cases:* Extreme cases are those which are very different from the majority of cases (in either a positive or negative way). Extreme cases are very useful to the data analysis because, by comparing the results of extreme cases with other results, it is possible to clarify the key factor that accounts for the difference.
- *Ruling out spurious relations:* By critically examining conclusions, the researcher must consider the possibility that a "third option" is the real explanation for patterns in the data.
- *Replicating a finding:* By including data from several independent sources, validity can be increased. In this research this will not be possible because there is not another group in Huddersfield that is similar enough to allow for valid comparison.
- *Checking out rival explanations:* By using someone as a "devil's advocate" in later stages of the research to question why any previous hypothesis are not supported by the data, researcher "tunnel vision" is supported and validity is increased.
- *Looking for negative evidence:* The researcher must actively seek to disconfirm what they believe is shown by the data by going back through the data and looking to disprove conclusions.
- *Obtaining feedback from informants:* Informants should be given the opportunity to offer feedback on conclusions. This is a method that is especially appropriate for case-study research on PHEs because of the

participatory nature of the programme itself, and it will be a main method of increasing validity of data.

By always maintaining a critical eye, being explicit about assumptions, and ensuring that informants and a "devil's advocate" have an opportunity to review data and conclusions, the validity of qualitative research can be increased.

Subject Selection

For this study the entire team of PHEs (n=10) was invited to participate. The reason for inviting the entire population was twofold: (a) Each PHE has a unique experience in the programme, and interviewing the entire team gives a more complete picture of the phenomena of transforming from a natural helper to a lay health advisor; and (b) the number of potential subjects is small enough that data can be collected from the entire team. The decision of each PHE to participate in the study was voluntary. Before any data were collected, the project was explained to the PHEs in detail (both verbally and in writing), and informed consent was obtained. In addition, each participant reaffirmed his or her informed consent before each segment of the data collection and maintained the right not to respond to any question and to withdraw from the study at any time without negative consequences.

Data Collection

To respond to the research question and subquestions, two means of data collection were used, PHE journals and individual interviews.

PHE Journals

The PHEs attended a 14-week (2 x 7.5-hour sessions/week) training programme to prepare them for their role. At the end of each training session each PHE was required to fill out a daily reflections journal (Appendix F), which was then handed in to the Peer Health Education Coordinator; thus the PHEs were aware that others would be reading them. In this journal they were asked to record what they had learned and their reaction to the material, and to reflect on linkages between the training content and the role of the PHE. These journals were used to provide insight on the effect of training on the development of each PHE and on the PHEs as a group. Participants chose whether or not to allow the researcher to use the journals for the study, and they were assured of confidentiality and that their names would never be revealed in the study.

Individual Interviews

In-depth individual interviews were used to assess the following: participants' initial motivations and expectations upon joining the PHEP, reflections on the training programme, personal perceptions of the effects of the PHEP on the PHEs themselves, their experience of contact with health care staff, and their level of empowerment.

At the beginning of each interview, the purpose of the study was reiterated, and informed consent for continued participation in the study was obtained. The interview consisted of open-ended questions, and participants were encouraged to "tell their stories" throughout the interview, with the interviewer "probing" and asking for clarification as required. Asking the PHEs open-ended questions reduced the risk of biased answers and encouraged the interviewees to voice their own opinions (see Appendix B, Individual Interview Protocol).

The interviews took place in private meeting rooms at the Princess Royal Community Health Centre (PRCHC) and at the Huddersfield Royal Infirmary (HRI), the PHEs' place of work. The meeting rooms that were used were neutral areas for the PHEs because they are not locations that are used during the course of their work. Because of potential difficulties with transportation for participants, conducting interviews at the PRCHC and the HRI was the choice offering the most convenience to participants.

For verification purposes, the interview data to be included in the report was forwarded to the PHEs for their approval, as well as seeking any additions and/or deletions. No refusals or changes were received.

Data Analysis

According to Yin (1994) and Bromley (1986), three different methods are used for case study analysis: exploratory/descriptive strategy, theoretical orientation strategy, and quasijudicial strategy. The exploratory/descriptive case analysis will guide this study. In this method data analysis and collection take place simultaneously. The analysis is both comprehensive and flexible (Munhall, 2001), with data being divided into small units for analysis and then reintegrated into a whole at the end. This strategy can employ a variety of analytical techniques, including content analysis, analytic induction, constant comparison, and phenomenological analysis. Once analysed, the data are interpreted. All interpretations made about the data must be firmly rooted in the analytic text; however, according to Munhall (2001), three main processes are used in interpretation: reflection, comparison, and creativity.

- Reflection must be both “personal and data bound”; however, any pre-existing assumptions held by the researcher, already made explicit to the reader, must be suspended during analysis to allow the true meaning of the data to emerge.
- Comparison is used at all stages of the data analysis, from coding to categorizing to contrasting evidence. Using comparison allows development of themes/patterns across the data and, eventually, the formation of a more general explanation.
- Creativity is used to help generate meaning in the data and must be blended with critical thinking.

In conclusion, for the purposes of this study, the exploratory/descriptive strategy is most appropriate.

The journals were analysed using thematic analysis (Morse & Field, 1995). Themes are concepts that are indicated by the data, and they are used to formulate tentative propositions about relationships within the data.

The interviews were transcribed, coded, and analysed. Although analysis was drawn from a variety of techniques, it used a systematic structure as follows. The transcribed data were considered as a whole. Using memoing to record observations, themes that emerged from the data were noted and used to guide the more in-depth content analysis. Guided by the emerging themes, and still open to new categories that emerged from the data, content analysis was completed. Data were coded and divided into broad categories to find patterns.

CHAPTER 4

RESULTS

Data were collected via two means: face-to-face interviews and PHE training journals.

Face-to-Face Interviews

All Peer Health Educators (PHEs) were invited to participate in face-to-face interviews with the researcher over a two-week period in March 2002. Of 10 PHEs originally recruited into the programme, seven were interviewed. Of the three who were not interviewed, one had ceased participation in the programme and was not in contact with the programme, one was on sick leave during the data-collection phase and was unable to be contacted, and one had left the programme to pursue a Master of Science degree in health promotion and was not able to be contacted.

Interviews took between 90 and 120 minutes to complete. One interview was incomplete and has been only partially analysed. All interviews were tape-recorded and transcribed and then analysed according to the proposed framework. Follow-up questions were asked to participants via e-mail and face-to-face contact.

PHE Training Journals

All participants were supplied with a postage-paid envelope and were invited to submit photocopies of their PHE Training Journals for inclusion in the research. Five participants submitted their journals, which were analysed at the same time as interview transcripts and in the same manner. Because the journals were used as a reflective tool for the PHEs during the training programme, they were analysed to gain insight into the impact of the training process in the process of becoming a PHE.

The results are presented here in correspondence with the five subquestions of the thesis question:

Subquestion #1

What were the participants' initial motivations and expectations for joining the Peer Health Education Programme?

In order to gauge the participants' level of transformation through their involvement in the PHEP, it is necessary to find out what they expected from participating in the programme. Participants were asked specifically about their motivations to become PHEs and their initial expectations of the programme.

Motivations

Out of seven participants, five applied for the position because they identified with the role. Although all of the participants were natural helpers in the community prior to applying for this job, each participant identified with the role of PHE with a greater or lesser degree of certainty. Two participants indicated that they felt a high degree of certainty that they could perform the role:

I thought that job had my name written all over it as soon as I read the job description. . . . There's no one better to relate to my peers than me. . . . I knew I had the willingness to do the job. I just wanted the right training just to harness all that energy I had coming through. [Participant #1]

And then I was thinking, "Well, I can apply" because they wanted two languages—English and one community language. I was thinking, "Oh, I can do that." [Participant #6]

Although other participants identified with the role, they were not sure that they would fit the criteria that recruiters were seeking. They took an approach of "give it a go" and "see what happens."

It were because it were looking for people that understood the African-Caribbean culture, and I thought, "Well, yeah, I'm African-Caribbean. I fit the description," . . . and some of the skills that they were looking for, and I thought, "Well, yeah, I think I've got some of those skills. I'll apply and see what happens." [Participant #3]

I didn't know what a Peer Health Educator might be, but then I looked at the details and I looked at the pack, and I saw that it was all related to my role [in voluntary service], so I thought I would give it a go. [Participant #4]

Since it had that theme of health, working in the community, I mean, it just seemed to fit the criteria within the African-Caribbean community, family support stream; and, I mean, I think I've had a bit of knowledge and experience in all those fields, so I might try and see how it goes. [Participant #5]

Another motivation for some PHEs was community betterment. Two out of seven participants cited this as a motivation for applying to the programme:

To make a change in Huddersfield in a health related way. [Participant #1]

I was one of the first group who arrived to Huddersfield, and I faced a lot of problems, and I could feel how my community is going to suffer. . . . I wanted to help my community because it is strange for them. [Participant #2]

Four out of seven PHEs cited other personal reasons for applying, ranging from finding a job that fit in with her lifestyle to fulfilment of a personal goal:

Went in to nursing at the age of 18, general ward nurse, and then got my RMN, which is a Registered Mental Nurse. I did nursing for many years, came out at the end of '95 due to ill health. . . . Decided that I couldn't continue as a nurse but I had difficulty finding work that was suitable for me. . . . I wanted something where I could use some of the skills that I gained from nursing. [Participant #3]

I was constantly looking round for work and looking for a part-time job so that I could spend time with my children. [Participant #4]

I think it [taking job in order to improve English] was really good idea, and that's why I am here. Because at work I am speaking English now, and I am improving every day rather than studying books and reading books for English. [Participant #6]

I've always wanted this job because I like helping people. [Participant #7]

Outside support and encouragement were cited by five out of seven participants as a major reason for applying for the position of PHE. For three of the five, the outsider identified them as people who would be well suited to the role of PHE"

But if it were not for [someone] at Worklink who rang me and said, "... I've come across this and it strikes me as something that would really, really suit you. Do you want me to send you the details?" ... with her encouragement, I actually applied for the job. [Participant #3]

Somebody said, "Oh, it's good, you should take it; it would be good." And I tried it, and here I am today. [laughs] [Participant #5]

Then I saw [another person who was applying to be a PHE] down at Ashbrow [children's nursery], and she told me about this job, about the Peer Health Education job. ... She said, "I think you'd be right good at it" ... You know, sometimes people from outside can see more than you can see. So I thought, "Well, I'll give it a go," and I got an interview. [Participant #7]

The fourth individual (Participant #6), a recent arrival to England, was encouraged to apply for the position by two people: one who was an employee of the NHS Trust and in the same Diploma in Interpretation programme as the participant, and by her husband because he considered working to be a better means of improving English skills than taking English lessons:

At that time I was doing diploma in interpretation, so one of the Linkworkers [interpreter who works for Huddersfield NHS Trust], she was doing the same thing, and she suggested me to apply for this job, and she gave me the information about it. ... My husband, he always he used to say me, "You can learn a lot when you are working rather than going to college" ... At work, he was saying,

"You will stay there six or seven hours, and all the time you are there you will speak English. You will learn a lot, and you will improve in this way."
[Participant #6]

A fifth individual sought reinforcement of her intention to apply for the position from a member of her community group whom she respected:

I had a word with . . . the Public Affairs Secretary. . . . You know, he's quite knowledgeable, he knows quite a lot of things; and I said, "Is it okay if I went for this job you think?" and he said, "Why not give it a try?" [Participant #4]

Expectations

When asked about their expectations of the PHEP, most responses were vague.

Overall, participants indicated that they were not exactly sure what a PHE actually was or would do, but five out of seven participants indicated that they expected to be giving health information to their peers:

I assumed it would be delivering like health topics to people just like myself. . . . My background, and it's been like that. [Participant #1]

As far as I knew, that they were going to deliver the information help their community. [Participant #2]

Not me with my nursing background, but me with a bag of skills to go out and talk to my own people, African-Caribbean, and talk about ways that they could look after themselves. [Participant #3]

I knew it was something about health, people wanting some information, giving them some information and stuff. [Participant #4]

But when I read the job description, I found out it was also giving people information, it was not just translation. [Participant #6]

Once into the role of PHE, many found that the position was much less structured than they had anticipated. Four out of seven indicated that they thought the job would have

much more structure to it. Combined in some cases with feelings that there was a lack of a defined role for PHEs, this created some feelings of frustration and confusion. This topic will be further discussed in the next section, which describes the perceptions of the effect of the experience of working as a PHE on themselves.

The majority of PHEs did not mention any preconceptions about what working for the Huddersfield NHS Trust might be like. Two participants did have ideas about the expectation of the Trust: One participant (Participant #2) believed that the Trust expected the PHEs to succeed in reaching out to hard-to-reach communities, and one PHE (Participant #1) held negative initial suspicions towards working for the Huddersfield NHS Trust:

Trust thought that there was a new community in this area. . . . They never had refugees in this area, so I think that they were aware that they need a Peer Health Educator because they are new in this area. They have no idea what kind of services are available in this area. . . . I think they knew that is necessary to have a Peer Health Educator to lead these people, . . . to deliver this information on issues to this community. [Participant #2]

I thought they might try to change the way that I was, the way that I worked. . . . I thought, when I've always thought about the Trust, I thought it was more stuffy, more not black, for a start. [Participant #1]

In summary, most participants were motivated to apply because of a combination of factors: identifying with the role, perceiving the job as something that fit their personal needs (time, skills), and encouragement from outsiders. Of these, receiving positive encouragement from outsiders seemed to be the key factor. Although uncertain about what exactly the job would entail, the participants expected that their role would centre around giving health information.

Subquestion #2

What are the participants' reflections on training?

In addition to interview data, data from the journals that the participants kept during the training period were analysed to assess the participants' perception of the training programme on themselves. This section deals with only the perceived effect of the training programme and does not probe issues such as training content or quality.

Reflective Journals

Five of seven participants submitted reflective training journals for inclusion in analysis. The journals contained variable amount of detail, ranging from simple reiteration of each day's events (one journal) to in-depth personal reflection and analysis on the training programme (four journals). The reflective journals were not designed specifically for this study, but were a tool used by the Peer Health Education Coordinator during the training period. For this reason, the amount of data germane to this study was limited.

Over the course of the training, three of five journals (Interviews #4, #5, and #7) built up a profile of what they expected the role of the PHE to be. For the most part, there was a direct relationship between the training topic of the day and the development of role expectations. That is, participants assumed that whatever was taught on a particular day would form a part of their job. Table 3 summarises the expectations that these participants formed about their job during the training period:

Table 3

Expectations About the Job During the Training Period

Activity*	Participant #4	Participant #5	Participant #7
Help people to help themselves	X	X	
Understand and educate on the role of culture in health	X	X	
Understand and educate on the role of inequalities in health	X		
Encourage participation	X	X	
Use good communication skills	X	X	X
Educate/give information about health issues	X	X	X
Maintain confidentiality	X	X	X
Set targets/assist with evaluation	X	X	X
Facilitate groups		X	
Use stages of change model		X	
Direct people to resources	X	X	X
Partner with other people and/or organisations		X	
Perform community needs assessment	X		X

* Listed in order of appearance in journals

In all of the journals (5/5) the participants indicated a preference for practically oriented training styles and indicated that they felt that they had learned more when a practical training style was used. An illustrative example follows: All five journals mentioned in detail an exercise called the "Power Walk," presented in the context of the effect of inequalities on health. This involved role play in which some PHEs played a range of individuals in society—from those who hold a lot of power (a doctor) to those who hold little power (a single parent working as a cleaner). A series of exercises

illustrated that people in powerful positions in society are able to move ahead more easily than are those with less power. This exercise was described in all journals as one of the most memorable and powerful exercises in the training programme.

Interview Data

One difference between reflective journals and interview data is that, in the reflective journals, PHEs tended to indicate that "everything" they learned in training was useful; that is, that the "training of the day" would be directly applicable to their work as PHEs. During the interview the participants were asked to describe the parts of the training programme that they found most useful (Table 4). Frequencies were counted once per respondent (i.e., regardless of the number of times a particular element of training was mentioned by a participant, it was counted once).

When asked to describe the impact of the training on themselves and their life outside the PHEP, six out of seven participants reported overall positive feelings about the training. However, one PHE reported extremely negative effects due to participating in the PHEP that can be linked to the training programme:

[I learned] how to gain their trust, how to make them feel, . . . how you can make them trust you, how you can gain their love, how you can deal with them and how to don't judge them. . . . I got affected too much on my personality. . . . It affected my personality, . . . to feel their feeling, to put myself all the time in their position, to make them feel happy and that I am doing as I can for them, and to make them feel that I'm doing my best. I want them to feel like I am their friend. I want them to feel like that. [Participant #2]

This PHE reported very negative effects from participating in the PHEP because of feeling the burden of client problems. These will be described in "Discussion."

Table 4
Most Useful Parts of the Training Programme

Part of the training programme	Frequency of response* (n=7)
Information on particular diseases/conditions/skills	6
Assertiveness	3
Awareness of resources	3
Helping people change	3
Communication skills	2
Confidentiality	2
Presentation skills	2
Definition of health	1
Definition of health promotion	1
Evaluation	1
Respecting clients	1
Role of PHE	1

* Respondents may have reported more than one part of the training programme

PHEs reported an increase in feelings of confidence and/or self-esteem as a result of the training programme. Three out of seven PHEs reported such an increase:

I think a lot of us needed our self-esteem developing anyway. So I think that the training did help us with that, and from my personal experience I would think so because although I'd been in community work, I'd been looking at it from a different angle, and I felt that my self-esteem needed boosting in what I was going to do. [Participant #5]

I wasn't like so confident, but as I was like doing my training and after that, I was a bit better. Now I'm a lot better really. I think it's just 'cause of my job, because I'm going there and meeting people and I'm speaking a lot now, so that's why my English is improving. [Participant #6]

I've always wanted to buy my own house, and it's really made me go, "Yeah, you can do it. You can get yourself a better job and better position and things like that." You don't have to sit around and think, "I want this and I want that" and just sit at home. You have to go out there and do it for yourself. More ambition. [Participant #7]

Three out of seven participants reported increased self-awareness during the training period. By seeing themselves reflected back through other people, they became aware of how their colleagues perceived them:

I felt excited and to a certain extent in control. I was aware of the dynamics within the group. I realised at the end of the exercise that my confidence upset a few of the team, but I also felt it made us become closer. We knew a little more about each others strengths and weaknesses. [Participant #3—from reflective training journal]

It made me see the inner side of me a bit more, which I would have put down [before]. [Participant #4]

I think sometimes I have that tendency where I can be very overpowering . . . in a group setting because of how I might speak or how I might work, . . . and sometimes that can be seen as domineering, and you don't think you're doing it. But I think working in groups and some of the training that we did helped me to realize that I can be seen as domineering or overpowering to people when I'm really not wanting to be, so it made me look at how I'm talking to people, how I'm going to work with groups of people that I must really watch my p's and q's—my body language, how I really talk, how I might respond to something somebody asks me and not make them feel inadequate where, you know, I think I have had a tendency to do that. [Participant #5]

According to the data from the training journals, many participants formed a concept of what they expected the role of a PHE to encompass. On an individual level, many participants gained self-confidence and self-awareness during the training period.

Subquestion #3

What are the participants' personal perceptions of the effect of the experience of working as Peer Health Educators on themselves?

Using data collected during the interviews, the participants were asked to describe the effects that working as PHEs had on them. After the structured training programme, they expressed feeling a bit lost in their role, stating that they lacked guidance and a discernable workplan. Most were clearly expecting a more structured and identifiable role:

I think what I expected from the programme, . . . I think, was a bit more guidance, a bit more support. . . . I don't think I am clear about what we're about, so maybe clarification of the role. I feel very much though that I've had to, in a way, make the road of where I am going. We were given a heading of either family support or heart health. . . . When we finished the training, I didn't know how to go about that. [Participant #3]

When I did the job, it had a different role to it. I think just lately we've put a face to whatever it was meant to be, Peer Health Education. I think it was just a target to meet—all the information was there, but there wasn't no face to it, and we couldn't say, "This is what a Peer Health Educator should do." . . . We just couldn't put a face to it. Now we can say we've promoted health in various ways, we've got different people motivated in our community. [Participant #4]

I knew it wasn't office based. I thought that, well, we wouldn't have rules so much, but we would have things mapped out for us to do; you know, we'd have like a schedule of things that we would be doing on a day-to-day basis within the job as a Peer Health Educator. . . . After the training I found out that it wasn't really like that—that we had to use our own initiative and plan our own work schedule, but the support of the individual professional was there if you needed that support. [Participant #5]

I didn't really, like, know. I thought we were going to have like a set programme or something. I thought we were going to go into the job and someone was going to like set patterns up or work to stick to. I didn't realize that we were going to be like setting up our own programme. . . . I found that a bit tough, having to go out there. It's all right because I have a good idea, when I think about it, but to get it

off the ground and see it though, I think it's a lot harder than what I anticipated.
[Participant #7]

Although the participants expressed struggling with their role at the beginning, most concluded that, through their struggles, they were able to gain confidence and self-efficacy. This is described in the section on empowerment.

A recurring theme among participants was increased opportunities as a result of participation in the PHEP. Their 14-week training programme was not accredited by a university, but the PHEs received the opportunity to pursue either a certificate or a BSc in Health Promotion Studies at Huddersfield University. Although the PHEs have to pursue these studies on their own time, their tuition is paid by the Huddersfield NHS Trust. Six out of seven participants are attending university: four in the BSc Health Promotion Programme and two in the Certificate in Health Promotion Programme.

I've started uni, which wouldn't have happened without this post. . . . The fact that I'm going to university now is a big deal to me, and it is a big deal to my son as well. No one in my family has gone to university before. He wants to come to campus with me. To me there are no words to describe that. [Participant #1]

We're doing this degree in Bachelor of Science in health and community studies . . . on a part-time basis, one day a week. . . . It's good, and the thing that we do on the job, and that we did at the training, it's all health. Even though we couldn't see it at the time, we can APEL it for advanced credit . . . You know, so again as another step forward within the Peer Health Educator Programme, so if maybe in ten years time I might be lecturing in university on health or something like that. It would have all been worthwhile, because we count the knowledge, the experience, the training, the contacts. [Participant #5]

'Cause in this job I learned a lot of things, so that's why I went for this Health Promotion Certificate. I was thinking now I know I am going to do things.
[Participant #6]

I mean part of me is saying, "Well, you're going to be going to university for five years' time. You don't have to do that now." And I said, "Well, it's an opportunity, you know, my work's. I've got this new job, work's good, I'm going

to university, you know." I shouldn't lose a chance that I've got to take, you know. I'm not going to wait five years' time when I'm forty because I might not get that opportunity again, so I said, "Well I'm going to take this opportunity now." [Participant #7]

One of the PHEs who is attending university felt that it has caused a work-life conflict:

The only thing that was upsetting was that we didn't get accredited for [the Peer Health Education training] and had to go in to university that we're doing. . . . I'm actually going into university, I'm doing one day, and I think I made a mistake, but I'm still going. . . . It's like giving a lot of time, and then with children, it's really hard, . . . working with children, working part-time. But then this sort of gives me the feel that I've got to do part time as well as one day at uni, come back home and do some more work on the computer. With children don't hardly give you the time to do that, and it's like working time round. [Participant #4]

Although this PHE initially indicated that she would not continue taking university courses, in a follow-up discussion this had changed: Encouraged by receiving passing marks in her first-year courses, she decided to continue with her degree.

Two PHEs have also applied, and successfully competed, for additional health-related employment since joining the PHEP:

As a result of getting this post, I got taken on by Healthy Schools as well. And . . . so I work part time at Healthy Schools. [Participant #1]

I'm working nearly 28 hours 'cause I'm working fifteen hours with Julie Thompson's old people's group, and it's a shorter project. It will finish in May, June. [Participant #6]

Three participants expressed feelings of work-life conflict, with various degrees of expressed concern over this conflict:

It hasn't had any negative effects. I work a lot and I work irregular hours, . . . but [Participant #1]

I think I do think about myself a bit more, but I think it's more stressful now because I haven't got time to do things for my family like what I've done before. . . . My partner, you know, he's alright, he's got his ups and downs, you know. There was a bit of jealousy before when I've been saying stuff, but if I say anything negative, he'll jump on it. But if I say something positive, you know, he'll listen but he's not happy to hear it, and things like that. . . . He carries on about me getting dressed up and going to work, but you know, what am I supposed to do? It's really good in the way that he's pitching in with nursery, and he gets her [daughter] out and things like that, but there's still that part that thinks I'm just thinking about myself. It's just "me, me, me" all the time, and I'm just thinking about myself. You know, I do try and think about everybody. I can't be doing everything at once. [Participant #7]

When asked to express their long-term goals, most (five out of seven) were able to describe goals in specific terms. Two PHEs indicated that, although their goals have not necessarily changed since becoming a PHE, their goals seem more focused and achievable:

I feel like I've got a little master plan now. I think that it'll all just slot into place. Things always seemed to be a big struggle to get things sorted. . . . I'm gaining more experience of what type I work I want to do and actually doing it. And before, I was doing it but doing it on voluntary terms. . . . It was good, but it didn't pay the bills. So getting more experience makes my goals seem a lot more achievable. [Participant #1]

I'd like to be doing similarly to what I'm doing now—passing on information to people, helping people to achieve their goals around health or whatever. . . . I want to see myself doing a lot of outreach work again; you know, giving talks, going to conferences, passing on information. You know, I think that's what I would see myself long-term, and working for the community. . . . [In reference to BSc in Health Promotion] as another step forward within the Peer Health Educator Programme, so if maybe in ten years' time I might be lecturing in university on health or something like that. It would have all been worthwhile, because we count the knowledge, the experience, the training, the contacts, you know. . . . It makes all the difference. I'm more focused; I'm more, I would say anxious, but more keen than ever to learn new things, look at things differently, lay things out differently, and then I've done. So whatever I do, it must be productive and beneficial to the people that I'm there to help; and if it isn't, then it's a miss; you know, not worthwhile to do it. So, yeah, I'm more focused, I think, since becoming a Peer Health Educator. [Participant #5]

Three PHEs acknowledged that their goals had changed somewhat as a result of working as a PHE. Two are quoted below:

I'm thinking to do a post graduate degree. . . . It's an M.Sc. in Health Promotion, but you can do like just [post-graduate] diploma as well in a year. . . . I'd like to be a Health Promotion Specialist. . . . First of all, I need to do this [Health Promotion] certificate, and I think I need some more experience. . . . I am interested in two more years' experience . . . because, first, when I came over here, I was looking for teaching. [found out she would need additional qualifications to teach]. And I said, "I'm not going to do another five, six years!" Then I got this job, and so I was thinking "Now I'm doing health promotion work afterwards." I talked about it afterwards, liking to do something in health promotion now because I'm there now, so rather than teaching. [Participant #6]

When I joined the programme, I wanted a big house and money and all this luxury, but now I want to be able to do something where I am helping people as well; you know, I'm working my way up as well. So, yeah, I think they've changed. [Participant #7]

One PHE expressed a desire to return to her previous career once her contract as a PHE was finished:

I think that I would have my degree in civil engineering. I like the Peer Health Educators, but I like my job [as civil engineer]. . . . I have to study, I think, extra two years as a civil engineer to recognize my degree [from outside UK]. . . . Maybe after I finish my contract as a Peer Health Educator, because, you know, my contract is for three years. After that, I start to study. . . . At first I thought that I would begin studying straight away, but now I am working as Peer Health Educator for three years' time. [Participant #2]

PHEs discussed the way that their families, friends, and communities treat them in their role. As a group they have, overall, experienced positive feedback from friends, family, and community:

Lots and lots of positive effect. The fact that I'm going to university now is a big deal to me, and it is a big deal to my son as well. No one in my family has gone to university before. He wants to come to campus with me. To me there are no words to describe that. . . . He's seven, nearly eight. . . . He knows that a lot of my friends are in jail. He knows all about jail. On the other hand, he knows I'm studying, and he wants to do the same. . . . He's seen two paths; he's seen two

very different paths. I won't preach to him; he can see it for himself. [Participant #1]

Because a lot of people that approach me, . . . a lot of them know me, . . . you can tell that they're proud, and that rubs off. So I feel proud because they're proud of me, and that rubs off. So I feel really, really proud, and I feel as though I'm helping; . . . I'm doing something useful. [Participant #3]

Well, people look upon me as I've got a job now and I'm doing something, . . . and it's a good, recognizable job. . . . I think with the NHS, it's given me a better feel to myself and the people look upon me. They've come up to me and said that they've seen me help in the community, and they'd like to do something as well. And I've sort of given them advice and help, and two of them have now made careers themselves. [Participant #4]

People approach me all the time. They approach me for, "Oh, what do you think about this?" or "I'm doing this"; or people will send me a wealth of information because they know what I do: I'm a Peer Health Educator. . . . People see me and they know I'm a Peer Health Educator, and they know I work for the National Health Trust. . . . It's good that I'm recognized in that way so that they can feel comfortable coming and approaching me and asking me something. [Participant #5]

[My family] think I am a lot more knowledgeable about health than before. Before, they thought I was totally different, but now they understand that I know more things—like services. They ask me where they should go, like services for older people. If they need help, then I can give them information. [Participant #6]

One PHE reported success with her community in her role as a PHE, but she also reported that friends and family have felt that they have not received much attention due to time pressures on the PHE:

Well, there's been negative effects friend-wise because like my best friend lives in [nearby town] and she moved there when I got this post, but I feel like I haven't got much time for her. And the other thing is, since she moved, I never ever see her. Before I got this job, I would go out for days and we would do things together. Now I just never see her, and when I first got the job, she were saying that she could identify with my partner because "I just never see you. I know you've got a job to do and everything, but we just never see you. You just haven't got time for nobody else; you're just doing this job and doing this, and you haven't got time for nobody." And she was agreeing with him! And I were saying,

"You don't understand . . . If you were in it, you actually have to do it. I hope you understand." She weren't being really understanding at first, and like now, she's more understanding because she wants to do things, and I'm trying to help her now that she wants to do things herself, but I just haven't got no time.
[Participant #7]

In addition to implementing the techniques learned in training in their work as PHEs, many also report applying this knowledge to their own lives and to those close to them:

Like me and my mum, we do argue, we used to have a lot of arguments and things. I were talking to her; I tried to explain it in a way where I wasn't arguing with her, and that's through work. I try and get round and find another way and say, "Oh, have you thought of this?" instead of saying, you know, snapping back at her. [Participant #7]

I think so because in this way I will think, "Where am I on the cycle [stages of change]? . . . I think where am I, like am I ready to change or prepare to change? The other people, they don't know which stage they are on. But I am trying to change one or two things. [Participant #6]

My husband, . . . I made him to lose weight. [laughs] Yeah, he's lost about two stone with me bringing information back home and saying, "You should be more active" and trying things with the diet. What the dietician said, I knew it were really good because if it were working at home, I could make it work with other people as well. [Participant #4]

Since being a Peer Health she's become a diabetic, and I very much try and educate her about a type of diet, the diabetic diet. [Participant #3]

Participants cited the Peer Health Education team many times during interviews. Overall, the perceptions of the team were positive, indicating a great deal of peer support. Participants cited time pressures, various locations of work, and variable individual work schedules as factors in reducing PHEs' support for each other:

We do tend to try and support each other. . . . I think we do do our best, but I do find that, within our own little area, we do get really, really busy just like anybody else. Fourteen hours, or twenty-one hours, just never seems to be enough time. . . .

[If we could] all be under one roof, 'cause then at least we're seeing each other part way through the week and we've got a chance to talk. [Participant #3]

The participants recognised the importance of peer support and cited a desire for increased, regular contact with their peers, which could be facilitated by an office of their own:

[We] seem to share ideas and support each other, and I think that's really, really important, and I think the team, if we had an office of our own, then I think that would be better. I think it would help tremendously. [Participant #3]

I think just having events when you can sit down and get together, like an away day. We've never had an away day as a Peer Health Education team; we've always been put in with our colleagues from the Healthy Living Initiative and all the other groups and people, so we hardly have any time. [Participant #4]

I think we support each other in whatever way we can, regardless of what our background—I mean, there's a diversity, and I think we learn from each other. . . . We're rarely in the same room or the same group, all together at the same time, but I think we've emphasized that we're there; we've all got each other's telephone numbers. And you know, we meet up at team meetings, so we do get to see each other a lot and, you know, I think we've sort of branched off in little groups. . . . But then again that could be down to the community that we work in. . . . You know, but we meet up, we meet up in team meetings, and if there's anything, you know, anybody wants to know or anybody wants help or wants to do an event or an activity, and they want to know what sort of time you can give, people are quite willing to say, "Well, I can do this at such and such a time." So I think the support is there, and maybe it will grow and develop as time goes on, I don't know. I'd say for now it's okay; it's solid. [Participant #5]

Because we had our team meetings every two weeks, but we just got an hour, but in an hour everybody can't say all things they have to say, because we work very different hours. . . . So I think it should be more common hours really. That's what I would say, because in this way you can—like you're always there, and you can ask your colleagues some things. Now we are doing so many different things, and especially to people who work more in community than others, they sometimes don't know what goes on. . . . I think there should be one or two hours every day where they can share ideas with each other—what are they doing, how are they approaching this thing. In this way I think that we would learn things from each other. [Participant #6]

But I think we get on really well as a team. We're all, you know, really friendly towards each other, and we help each other. [Participant #7]

One participant highlighted the additional benefit of increased collaborative contact with her colleagues as a fringe benefit of participating in university courses:

Yeah, we've got different days, so when we do come in, we've only got a short time to sort of talk with each other. This course that I'm doing at university, I'm studying with my colleagues, . . . and I'm having more links with them in that way than I would have had being a Peer Health Educator 'cause I hardly have any time to talk with them as a Peer Health Educator. . . . [During class], you know, we really get close and attached and really help each other out. . . . It gives us a bit more time to know each other. [Participant #4]

One participant summed up the general feeling regarding the team of PHEs:

It's just that you have ideas, and we all just seem to click. [Participant #5]

One participant was based at a community medical centre and stated that she rarely saw her colleagues. Her colleagues, however, noticed her absence and expressed a desire to offer more support to her:

We hardly ever see . . . the woman who works with the refugees. . . . She sort of pops in here once a week and then she pops off, and it's a shame; . . . she's the only person that we don't see. I don't know how she feels, but we really miss seeing her. The rest of us seem to share ideas and support each other, and I think that's really, really important. [Participant #3]

Two participants have found a mutually supportive work relationship and described the positive effect that it had on their work:

Me and [another Peer Health Educator] got really close in the training. . . . I found that we formed a good working relationship as well. . . . I suppose I didn't feel I had to work totally in isolation, even though there were some things that I would do and there were some things she would do. . . . We got on so well together, it made everything just fit in so perfectly. We was in the same stream, had the same ideas. I think we sort of. . . . I don't want to use the word feed off each other, you know, to make it look like—. . . but we was both Black women. We had a good life experience behind that, we identified with that, and we really

did seem to click, and I think that made for me, being a Peer Health Educator in the family support stream, that much easier. [Participant #5]

You know, me and [Participant #5] help each other a lot; we really get on really well, and if there's anything that I can do to support her, I'll do it. Like tonight, she's got a course going based on infant massage and breastfeeding, and we're going to do that together. Like, I'm going to promote it and try to put up posters and stuff, but we're going to do it together. [Participant #7]

Although the participants admitted that they felt stress when they began their role because of the fact that their work was not very well defined, they cited increased opportunities and more defined goals as a result of working as PHEs. For the most part, the participants indicated that they felt that they were able to influence their community in their role as a PHE. With one exception, they have found significant support from their colleagues. However, some participants have experienced work-life conflict as a result of being a PHE.

Subquestion #4

What was the participants' experience of contact with health care staff?

The participants have an opportunity to interact with health professionals during the course of their work. The quality of this experience may affect their perception of their role as a PHE. Through interview data, the degree and quality of experience with health professionals were assessed.

In their role as a PHE, the participants work with professionals in both the Huddersfield NHS Trust and other community organisations. The participants reported variable experiences of contact with health and other professionals.

The first type of experience reported was that health and other professionals struggle to see a clearly defined role for PHEs. Although the PHEs themselves see their

role as distinct, professional, and performing a complementary service to other professional groups, this is not necessarily shared by the professionals with whom they work:

We are professionals—maybe not professional, professional in the way they might see, but we are working in a professional capacity, and a lot of the things that we do we can be held accountable, we can be liable for, so it's only fair that if the health visitors are going to be there respecting a nurse or a doctor, you know, we should have that sort of respect. [Participant #5]

There are occasions where Peer Health Educators are not taken that seriously, that we're duplicating work that's already out there, that we're not experts in that field. [Participant #3]

Two PHEs described an experience with health professionals that was negative for them. It involved the two PHEs giving a presentation on South Asian culture to health professionals at a doctor's surgery. The questions directed at the two participants were perceived as disrespectful towards their culture:

There were admin staff there, and we were expecting to do a presentation on our culture, and they didn't turn out as we expected. . . . We were giving the information and everything, and some of the questions that came out wasn't really nice. . . . You know, pinpointing on the negative side more. . . . I mean, they had questions, so obviously they've got to bring it out, but I didn't really expect them to come out with questions like that, or related to September the 11th. . . . There's one or two that were maybe sort of bringing out this conversation. . . . They weren't respecting your beliefs and your values. I felt really bad in there. . . . I told my coordinator that I didn't feel comfortable there. I don't know how the other people from the community would feel comfortable. So it sort of affects us straight away.

That was the first time it had happened. . . . There were like two or three women; you could sort of see them laugh and giggle between them. I think to let all the higher people know that you should respect and value the religion, not just say that, sort of when you go for interviews about racism and harassment and all that. It's not just saying it; action sort of proves it. [Participant #4]

There was one health visitor, she is a [coronary heart disease] nurse, and she was really nice. She was asking us, "Do you think I should wear trousers when I'm dealing with Asian people?" I said, "Not really," and the other people, they said to her, "Why are you changing your own traditions?" There's nothing to change their traditions, because all English people, they do wear trousers, don't they? And she was saying, "Why are you changing all your traditions for them?" She was saying, "I just want to improve, that's all." . . . They were asking about some religious things, so I said there are five things in Sikhism; like there is small comb; if you are better Sikh, you have to have a comb; that's normal. You have to have a short shorts, and uncut hair, and kirpan. That's the sword. . . . So I was telling them this and they said, "It's a weapon," and I said, "No, it's not a weapon; it's a symbol." But they were really, like, arguing with me. They were saying, "It's a weapon." . . . I said, "They don't use it for any kind of like killing people or like these kinds of things." . . . I felt really awkward; I felt really bad. And not all people were saying, but there were people who were really being awkward, and I felt really awkward in front of them. [Participant #6]

Both PHEs described the effect of this presentation on themselves:

And now I feel frightened to do it in front of the doctors, from that reaction that we got. So I think that will be upsetting. [Participant #4]

It is just a year I came here. I don't feel it's my country anyway, but when people like treat you like this, you feel really bad. I feel really bad. Sometimes it seems like it would be really good if I could go back and stay there. . . . We are foreigners anyway; we are not from here, but like we are human. They can treat you like a human. [Participant #6]

In explaining how she would deal with this situation, one of the PHEs felt that there was not much that she could do, other than reporting the incident to her coordinator and hoping that it would be taken up with the health professionals:

There's nothing much that we could have done except give feedback to our coordinator and give it for them to sit down in their community and get all the people together who can make a change really, anyone who wants to make a change at that high level. To get all the, maybe, the secretary or the admin and say that you've got to look at people. [Participant #4]

Both PHEs contrasted their experience at the presentation with their experience working with their colleagues in the Health Promotion Unit, indicating that they felt much more respected by their colleagues in the Health Promotion Unit:

When we came back, I said to my colleague, "Look at people in our Health Promotion; they're so down to earth. Look at [Health Promotion Specialist]; she's so high in level, and she's got so much knowledge and everything . . . Everybody's so nice in Health Promotion; you can never feel the difference. They treat you so friendly; you feel like you're at home. [Participant #4]

In the Health Promotion Unit, people are really nice. Really nice. We are very lucky. Those people are really nice. Everybody's really nice there. If I need to work with those kind of people, like who treat people like they are from another planet, then I don't think I can do it. I would rather stay home. [Participant #6]

A problem that plagues the PHEs seems to be the lack of a defined role, which is problematic both for themselves and for the health and other professionals with whom they work:

I'm not sure what they think we do. . . . Some of them do tend to think that some of the other Peer Health Educators are translators, which they are not. . . . They need to know what our roles are, how we can work together a little more. More contact. [Participant #1]

[Health professionals] weren't really quite clear about what we were about. I don't think I am clear about what we're about, so maybe clarification of the role. I feel very much though that I've had to, in a way, make the road of where I am going. [Participant #3]

I did feel a bit at first that we were a bit disrespected, and that we moved from pillar to post and stuff like that, and it did upset me a bit because I felt the respect wasn't there, and we didn't have a sense of belonging. . . . We didn't seem to be part of the team of the Trust sort of thing. I felt that a bit; I was a bit hurt by that, and I must admit I made it clear that I was [laughs], you know, but I think they have moved on a lot since. [Participant #5]

[The health professionals] initially thought we were going to come in with them. . . . They didn't realize that we were going to have all different programmes as well. They thought we were going to shadow them. Initially, I think they thought that we were going to shadow them. [Participant #7]

Despite role confusion, many PHEs have managed to form excellent working relationships with health professionals:

[Relationship with health professionals is] positive. They help me say more information which is related to health, but I didn't gain it during the training; I gained it from nurses or health visitors or GPs. . . . I feel that they like my work, they respect me. . . . I think that they appreciate my job. [Participant #2]

[Telling health professionals] "You know, if you come across anybody and you think they could use a Peer Health Educator. . . ." And they've been doing it. . . . It has been slow, but they've been doing it. . . . Know the ones that I've come across, like I say, they've been very supportive. . . . Personally, I didn't feel any sort of barrier that's been put up between us and them. . . . The referrals that me and [my colleague] have got through the health visitors have been quite good, . . . and a lot of health visitors, they were training to do infant massage anyway, so—but what I think they're saying now is that they haven't got the time, and that's where we could fit in with the infant massage. [Participant #5]

Because some people, some health professionals, they are really entrusted the work you are doing and in this way they can help us. [Participant #6]

When we started doing infant massage, . . . they're [health visitors] actually referring to us. [Participant #7]

Overall, the participants' experience with health professionals has been variable.

While citing supportive relationships, they also indicated that there is confusion regarding their roles and where they fit on the continuum of care. Two participants described markedly negative experiences with health professionals.

Subquestion #5

What is the participants' level of empowerment?

Empowerment is defined, for the purpose of this study, in accordance with Stewart (1990) and Booker et al. (1997). They define empowerment in terms of self-efficacy, development of a positive social identity, ability to transfer skills from one social domain to another, knowledge of social and political structures of the community, and using structure blaming rather than victim blaming.

Self-Efficacy

As documented under participants' motivations for joining the programme, all except two participants entered the PHEP with an uncertain level of self-efficacy that they could perform the role of a PHE. Eight months into the programme, the participants' self-efficacy had shifted: Five of the participants reported higher feelings of self-efficacy in their work. They felt able to influence friends, family, and community members, and were able to cite examples of this influence. Some of them attributed this to the knowledge that they received during training—the idea that “knowledge is power.” However, many of the participants cited the fact that they felt that their role was not defined and that they lacked support in their role as a source of their self-efficacy, turning an unexpected negative into a positive:

I would think that somebody was there to say, “Okay, you do this, you do that” and go from there, but it was all left on our shoulders, and I think that is what made me a good bit stronger, and I’ve learnt a lot from it. A lot of things that I know that would relate to the Asian community and from my own mind, and I’ve taken them up in the community. [Participant #4]

One participant experienced variable feelings of self-efficacy. Throughout the interview she cited examples of times when she had experienced success in her work, but she also doubted her ability to fulfil her role:

I think the expectations are great, and I don't know if I'm fulfilling the role. For me that's a negative, but I don't think it's really to do with Peer Health Education; I think that's me. I think there is so much to do out there, and it's a big responsibility. [Participant #3]

Another participant, who felt a high level of self-efficacy even when applying for the job, mentioned a positive change in his level of self-efficacy in his role as a PHE related to the knowledge he had gained in this role:

Things always seemed to be a big struggle to get things sorted. . . . when I was doing things voluntary, but being in this post I am able to like point people in the right way to get funding for things and stuff like that. I was just cut off from it all. I didn't know how to go about it. I can signpost people to organizations. [Participant #1]

In relation to his life, he mentioned feeling more in control:

I feel like I've got a little master plan now. I think that it'll all just slot into place. [Participant #1]

Although the majority of data indicate an increase in self-efficacy, one incident offers an interesting insight into self-efficacy in action. When Participant #4 presented to a group of health professionals who were, according to her, disrespectful and inconsiderate, she was very upset. Her response, however, displays a great deal of passivity:

There's nothing much that we could have done except give feedback to our coordinator and give it for them to sit down in their community and get all the people together who can make a change really, anyone who wants to make a change at that high level [Participant #4]

The participant felt that any change could not come from her initiative, but needed to be taken up by those at a "high level." It is impossible to discern from the data whether this represents a pattern in behaviour or whether this reaction is in response to this particular incident. In fact, this participant has demonstrated a great deal of initiative in other areas.

In most cases the participants described a high level of self-efficacy; however, one incident illustrates a disconnect between the high levels of self-efficacy described and self-efficacy practiced when an opportunity presented itself.

Development of a Positive Social Identity

Most participants indicated that their status within their respective community has improved as a result of their role as a PHE. They attributed this to the authority that they perceived that this role accords to them:

All of a sudden, they just think you're an expert . . . because a lot of people that approach me, . . . a lot of them know me from [before], and you can tell that they're proud, and that rubs off. So I feel proud because they're proud of me, and that rubs off. So I feel really, really proud, and I feel as though I'm helping; . . . I'm doing something useful. [Participant #3]

Well, people look upon me as I've got a job now and I'm doing something, and it's a good recognizable job. I've been working at other places like the school and then at the post office as well, but I think with the NHS, it's given me a better feel to myself, and the people look upon me. They've come up to me and said that they've seen me help in the community, and they'd like to do something as well. And I've sort of given them advice and help, and two of them have now made careers themselves. . . . I think because now the job gives me authority, so they've got to listen to you; otherwise they just ignore you. [Participant #4]

They approach me for "Oh, what do you think about this?" or "I'm doing this"; or people will send me a wealth of information because they know what I do: I'm a Peer Health Educator. Whether they might think it's beneficial, as long as it's got an emphasis on health and it benefits the community, I will get back the information. People see me and they know I'm a Peer Health Educator, and they know I work for the National Health Trust, so it's good that I'm recognized in that way. [Participant #5]

One of the participants indicated that, prior to becoming a PHE, he had a very strong, positive social identity; therefore his status within the community had not been radically changed as a result of his experience:

I was always sort of being in that role, but on a voluntary basis. [Participant #1]

Ability to Transfer Skills From One Life Domain to Another

All participants indicated that they are able to transfer skills from one life domain to another; however, the direction of transfer differs. Although most participants transfer knowledge that they have learned as a PHE to either their own lives or to their families and friends, two participants (Participant #1 and Participant #5) cited transferring life skills that they had acquired before becoming a PHE to their work:

[I use] the same sort of principle as I use with my own son, not try to, just not be preachy. Not be judgemental. Acknowledging that, yeah, people do have problems, but there are ways to avoid these problems. You don't have to follow the crowd. [Participant #1]

Knowledge of Social and Political Structures of the Community

All participants were able to describe social and political structures within their own communities; however, only three participants related this knowledge to their work as a PHE. Although not expressing reasons for the following statement, one participant also identified racial structures that she had personally experienced. This statement was in the context of describing the populations in which she has worked:

I think I've always tended to shy away from working with English people because I've always felt that I've never fitted in somehow. [Participant #5]

Shift From Victim Blaming to Structure Blaming

During interviews, when asked to identify reasons for ill health in the community, most participants cited lack of knowledge as the main reason. Some participants indicated that they hold an understanding of structures, but none connected structural inequalities to ill health. The attitude that "knowledge is power" is predominant:

Because I know what I'm doing. As a Peer Health Educator, you've got the knowledge there, and you're not giving out wrong information. . . . I know there's health problems, but the main problem is for them to sit down and listen. Honestly, because I can bring them round and give them health information, but what I need is for them to sit down and listen 'cause they can get a lot of benefit out from that. [Participant #4]

Information, education, reading material, resources, speakers coming in, people getting in conferences, seminars, workshops, discussion groups—all that has potential for helping people change their lives. But I know some of that's very hard to do 'cause I've been to conferences and I've been to workshops and things, and some of them are very poorly attended, given the fact that those are health issues out there. Sometimes there are issues; it could be, I don't know, fear or "can't do it" or too old or "I've been doing this for years; how can I change?" And, you know, that's where the support, the information, the knowledge, and advocacy, the befriending comes in. [Participant #5]

Only one participant cited structural issues as a reason for poor health:

Health problems? The most serious one is depression. All of them are suffering from—I think only refugees and asylum seekers have this problem because of the problems that they face when they moved to this country. . . . My community have no right to work for six month, so you can imagine how they are going to spend this time for six months. No work, not at all, And they are coming to another country where people don't speak their language. . . . How you are going to buy something? You can't tell what you want. So all of these things are affecting people and their health and depression. In my community, as especially they could spend their time on any good job, I think they would feel better for they will not be with that big of a space, you know, when you are free of time and have no job to work. I think if there are something else, activities or something to help them spend this time to be healthier or useful for them. [Participant #2]

Although the participants indicated that they were aware of structural issues that can affect health, only one made a direct connection between ill health in the community and structural causes.

CHAPTER 5

DISCUSSION AND CONCLUSION

Although each Peer Health Educator has a unique experience of becoming a PHE, commonalties exist in their journey. Before summarising the lived experience of the PHEs as a group, I will discuss each component of the analysis on its own, summarising at the end.

Let us begin at the beginning. More than half of participants were motivated to apply for the position because it responded to their personal needs and wants. A few reported applying to the position for reasons of community betterment. Although the range of motivations cited by participants is narrower than those in the limited literature on the subject, the combination of self-oriented and other-oriented motives is consistent with the literature (Ramirez-Valdes, 2001). Most of the participants cited outside encouragement as the reason that they applied to the Peer Health Education Programme. Although they suspected that they could perform the duties ascribed to the role, they needed extra encouragement from trusted and respected others to give them the confidence to actually apply. This underscores the importance of recruitment methods for lay health advising initiatives: It is important that key community members be engaged in the recruitment process so that they can encourage suitable members to apply. Another strategy would be for recruiters to engage in the targeted community, build trust with community members, and provide encouragement for interested people to apply to these positions.

The participants developed their perceptions of the role of a PHE in part during their training period. In the absence of a clearly defined task description, the participants

formed their vision of their role based on topics included in the training programme. In doing so, they built expectations of what their role would entail. Once they began working in the community, they needed to redefine this role.

Once in their position, most participants were expecting much more structure in their role. Although they were expected to define their own opportunities and activities, they cited that they were expecting more ascribed duties. When faced with a large amount of freedom in their post, instead of feeling liberated, they reported feeling frustrated and stressed. This became a positive in some cases: Once they felt that they had found their feet, they looked back at the experience of defining their role as positive. Coming into a new job, in a new field, is a giant leap. Although they were full of passion and energy, it was an even bigger step to have to define their own work. Support from coordinators and other trusted professional colleagues is extremely important during this stage. The participants indicated that they felt that they needed a great deal of support during the early stages of working in the community. Many participants cited the need to feel grounded during the early stages when they were defining their role and finding their place. It appears that very intense coordination is needed at the early stages of a lay health advising programme.

Although only one participant mentioned preconceptions of the Huddersfield NHS Trust as being a White-oriented organisation, the observations by this participant are important to note. The fact that these perceptions were altered as a result of being employed by the Trust underscores the potential opportunity to build bridges between an institution and a community through programmes that involve community members in a traditional institution. Of course, in order for this opportunity to have a positive outcome,

the institution must be ready to employ community members. Some other comments received from PHEs demonstrate that although some areas of the Trust (i.e., the Health Promotion Unit) were ready to support this new group of paraprofessionals in this initiative, other areas of the Trust were not necessarily as receptive of the PHEs. Based on participant data, it appears that a lack of understanding of the role of the PHEs and how the role interacts or intersects with the role of the health professionals, and a suspicion that the PHEs are not qualified or capable to perform their ascribed role interferes with the development of synergistic and harmonious work relationships and the maximization of the role of the PHEs. This is consistent with the literature (Giblin, 1989; Jackson & Parks, 1997) which states that gaining acceptance from health professionals can be a key difficulty for lay health advisors.

PHEs recognised the value of support within the team and wished to maximize the time and space available for interaction among their PHE colleagues through more opportunities to work with or share ideas with one another; they also expressed the desire for a space of their own. The PHEs are one team within the Huddersfield Healthy Living Initiative, and although the participants mentioned their PHE colleagues a great deal, particularly as a source of support and ideas, they did not mention their Healthy Living Initiative colleagues in the same way. The participants seemed to view themselves as a distinct group of paraprofessionals.

During the training programme proved to be a period where PHEs gained self-awareness and, through the experience, increased levels of self-esteem. This is consistent with the literature (Beam & Tessaro, 1994) which states that training can play a role in empowerment. One PHE (Participant #2), however, mentioned the empathy skills learned

in the training programme and indicated that, because she is always striving to put herself in the position of the client with whom she is working, she takes on the clients' emotional burden. Therefore, she had had some negative experiences as a PHE. The case of Participant #2 will be described in a later paragraph.

With respect to providing additional training opportunities, the PHEP appeared to be very supportive of the participants. Six out of seven participants are attending university courses, which are taken on their own time but paid for by the Trust. According to most participants, this is an opportunity they felt that they would not have otherwise had they not joined the PHEP. Again, this is consistent with the literature (Eng et al., 1997) that indicates paraprofessional lay health advisors have additional opportunities for career advancement. Being able to obtain university credit was very important to the participants and was viewed as a value-added undertaking. In a time-limited project such as this one, providing the PHEs with a recognised training programme is something that will pay dividends to the participants even if the programme does not continue past its original funding.

Finding indicators on empowerment that accurately capture the experiences of a group of individuals is extremely challenging. From the data and type of study performed, it is possible to describe ways in which the participants feel empowered. However, the choice of indicators itself limited the researcher in capturing only selected experiences from participants. The indicators selected for this study were based on those used to study other lay health advising programmes, such as those studied by Stewart (1990) and Booker et al. (1997). However, the indicators may not have captured the full experience of empowerment in the PHEs who participated in this study. Indicators

selected were self-efficacy, development of a positive social identity, ability to transfer skills from one life domain to another, knowledge of social and political structures of the community, and shift from victim blaming to structure blaming.

Beyond the indicators used in this study, the participants expressed one common theme: They felt empowered through the knowledge that they received during their training programme. To the participants, knowledge is power, and poor health stems from a lack of knowledge. Sophisticated recent health promotion theories routinely dismiss a direct connection between knowledge and behaviour change, although these theories predominated in the early days of health promotion. The shift in health promotion theory from knowledge as a key factor to more complex mechanisms, such as those outlined in the Stages of Change model (Prochaska & DiClemente, 1982), mark an evolution in health promotion. This evolution may also apply to the participants in this study: As they progress in their practice of health promotion, perhaps they will also conclude that knowledge is only one component of power and will make more sophisticated connections. Therefore, the focus of the participants on knowledge as the source of behaviour change could be regarded as one stop on their journey to becoming a lay health advisor who uses more sophisticated interventions. This finding can be linked with Beam & Tessaro's (1994) model of lay health advising (Figure 2), that describes lay health advising at potentially three levels: individual, social, and community. In the case of the PHEs, they are working mostly at the individual and social level, but have not yet begun working at the community level. Because the community level is linked to the individual and social levels of work, Beam & Tessaro's (1994) model could be used as a tool to move the PHEs into work at the community level.

The empowerment indicator of self-efficacy is distinctly related to the participants' reporting of strength that they gathered from knowledge. They reported that their self-efficacy has improved as a result of feeling more knowledgeable. Because they perceived that this knowledge allowed them to influence their friends, family, and the wider community, they felt more confident. Because this study measures the perceptions of only the participants, it is impossible to discern what degree of influence, if any, they actually have over others. To the participants, however, what increases their self-efficacy is the fact that they felt that they do have this influence. This is consistent with Beam and Tessaro (1994), who state that information shared with lay health advisors in the context of training is a means of empowerment.

The data indicate that the PHEs have not shifted from victim blaming to structure blaming. Although the PHEP training programme discussed larger structural reasons for ill health, only two participants made the connection between structural issues and health. Other participants attributed "bad" habits on the part of their clients to lack of knowledge and/or effort, not to structural issues. Again, this can be linked to the Beam and Tessaro's (1994) levels of lay health advising: PHEs focus on the individual level of work.

Participant #2 was an outlier case, reporting much different experiences from those of her colleagues. At the participant's request, the recording of her interview was paused halfway through, following a question in which she was asked to describe the effect of participating in the PHEP on herself. The participant and the interviewer agreed that everything discussed off tape would not be included as data. Participant #2 is an outlier in many ways: First of all, her work is much different from that of the other participants. Not only is she physically removed from the rest of the team because she

works at a different site, but she is also the only PHE who is not participating in the university training programmes, meaning that she misses out on one more opportunity to interact with her colleagues. Her role has also evolved differently from that of the other PHEs: Rather than creating health projects, her role consists primarily of language interpretation while working alongside health professionals. Her role has affected her differently from that of the other participants: Although she felt that she was making a difference in her community and that her role is important and valued, she also felt "how they [refugee/asylum-seeker community] are suffering" because of the conditions imposed on the refugee/asylum-seeker community, such as food vouchers, high stress levels, and a lack of the right to work. In fact, this participant was the only one of two who described a link between structural barriers and health issues. Although she felt that what she learned in training is very important, she also stated that the empathy skills she learned "affected too much on [her] personality. . . . To feel their feeling. To put [herself] all the time in their position."

This underscores important issues relating to the support that is made available for PHEs. One could postulate that the problem relates to boundary setting on the part of Participant #2. However, other PHEs spoke about setting boundaries with clients and using this technique to prevent getting too involved in the lives of their clients. This was not possible for the PHE who cited a negative experience. The other factor that distinguished this PHE from the others is that she had recently arrived in Huddersfield and may not have had the external support network that the other PHEs had. All of these factors underscore the importance of intensive support and monitoring of PHEs, especially as they begin their role, as well as the need to be aware of their stress levels.

Considering a comprehensive view of the results from this study, what is the answer to the research question: What is the lived experience of the transformation from a lay natural helper to a paraprofessional lay health advisor?

The transformation from lay natural helper to paraprofessional lay health advisor began even before being hired as a PHE – it began during the application process. As a group, the participants began their journey believing that they could probably perform the role of a PHE, but they lacked the self-confidence to apply. It was thanks to outside encouragement that most of the participants applied for the position, believing that without this support and encouragement they might not have taken that step. The training period was the first major transformative experience as a PHE. During this period, they met the other PHEs, gained health-related knowledge, and learned many skills relevant to their job. For the participants, the training programme led to increased feelings of self-esteem. Because they are more knowledgeable, they felt more confident and more powerful. As well, based on what was taught in the training programme, the participants formed a picture of what their role would entail after the training period. The next stage in their journey of transformation was the end of the training period followed by the beginning of their work in the community. These stages were marked by a great deal of uncertainty: They entered a tunnel.

The concept of role that the PHEs formed in training was not reflected in reality. Although they expected a structured role, with tasks outlined, they were faced with something different: having to go out into their communities to create relevant projects. They felt that their role was unstructured and unsupported. In addition, not only did health professionals in the community not understand their role, but in some cases they

also did not respect the PHEs. The light at the end of the tunnel, and the next stage of their transformation, came when they persevered and experienced success in their role, successfully helping friends, family, and community members to make changes in their lives. By having to work independently to define their work and their role, they felt intensified feelings of achievement and pride in their accomplishments. Although the PHEs make interventions at the level of increasing knowledge, they do not yet connect their knowledge of social and political structures in the community to their interventions. Consistent with the literature (Bellin et al., 1967; McCormick et al., 1989; McFarlane & Fehir, 1994; Westheimer et al., 1970), their status in their communities has been elevated: people identify them as a PHE, see them as having a respectable job with the National Health Service, and seek information and advice from them on health issues. The PHEs themselves include their role in their personal identity, and view the team of PHEs as a group of paraprofessionals who provide a complementary health-care service. There was a spill-over of professional life into personal life: Although finding a work-life balance proved to be a challenge, the PHEs have also brought their new-found skills and knowledge into their personal lives, helping both themselves and family members to make changes. Even during this period, the other PHEs have proven to be a source of support.

The next stage in their journey of transformation brings the PHEs beyond their immediate role as PHEs and into the future. Beyond their job, the PHEs have found increased opportunities, including access to other health-care jobs and education. Participating in university courses that contribute to a BSc in Health Promotion has been

the most significant opportunity. If they had not become PHEs, most of them would not have had an opportunity to attend university.

As a result of their journey, the PHEs have more defined goals, which they felt confident that they could attain. Things seem to be "slotting into place." They spoke with confidence, felt that they could use past successes as an anchor for future ones, and looked forward to future opportunities.

The journey of becoming a PHE is not straight and narrow. The path allows for divergence, and there are setbacks along the way. Support has been a significant factor in continuing the journey, and the excellent camaraderie and team support among the PHEs is a key to success. Finding ways of offering more support, such as more frequent team meetings and more opportunities to share insights relating to the role of the PHE, would make the transformation easier.

Methodological Issues

Indicators and instruments to measure level of empowerment among the participants were adapted from those developed by Stewart (1990) and then refined by Booker et al. (1997) for measuring empowerment among lay health advisors in a migrant farm-worker community. Although the Huddersfield PHEs share many characteristics with migrant farm workers—ethnic minority, tightly knit community group, a common religion—the indicators may not be the same for both groups. When planning the study, I thought that there would be a certain common thread amongst empowerment for all groups; however, while interpreting this data, I realised that empowerment is a fluid concept: One person's empowerment is not necessarily empowerment for another person. Because this group of people may have a unique definition of empowerment, it would be

interesting to conduct a future study with them to develop indicators through grounded theory.

Further research on organisational readiness to accept paraprofessionals is one area of further study. Another area for further study would be strategies used to successfully integrate paraprofessionals in an organisation.

Although recruitment strategies are not explored in this study, this may be an area for future research: looking at the relationship between coincident life events and work as a PHE.

Another limitation of this study is the fact that the data only provide a snapshot of one moment in time. If this study were to be repeated, I would perform a more longitudinal study, gathering data at several intervals to provide a more complete picture. Data gathered from participants could be skewed because of how they felt on the day that they were interviewed. For example, if a participant had just had a very positive week, this may have prompted them to give an over-positive interview. Gathering data over time would have given an opportunity to observe any "ups and downs" in the data and observe persistent patterns in the data.

Related to this is the lack of comparison or baseline data in this study. Because the PHEP is a relatively new programme, there was a missed opportunity to gather baseline data from the PHEs when they were first recruited. This illustrates the importance of building evaluation and research into a programme when it is being designed. In this study the participants were asked for their perceptions of change—if they believed that they had changed as a result of becoming a PHE. There is no way of

measuring the accuracy of perception; therefore it is impossible to measure the actual change and we rely on the PHEs' perceptions of the differences that occurred.

Limitations of the Study

Limitations of a study are ascribed by the setting or environment. This research is limited as follows:

First of all, the number of subjects was limited because of the size of the PHE team. Second, because of the distance that separated the researcher from the PHE team, there was no opportunity to return to the PHEs in the event that more data gathering would be useful to the study. This distance also limited the opportunity for casual observation of the PHEs that may have been useful for the study. Finally, the researcher may have been perceived as having power over the PHEs, which might have influenced the quality of data. However, the researcher was cognisant of this power differential and took steps to minimise this differential throughout the data-gathering process.

Delimitations of the Study

Although it would be ideal to create a comprehensive study that looks at all sides of a topic, this is simply not realistic. It is necessary to delimit a study to make it feasible. To *delimit* means that the researcher imposes boundaries on the research. These boundaries at once make the study simpler to conduct and affect the robustness of results.

For this research, there are two main delimitations that place boundaries around the research. The first is the choice not to use a comparison group. In their 1997 study on lay health advisors working with migrant farm workers, Booker et al. studied changes in empowerment amongst the lay health advisors. Because both the lay health advisors and the comparison group lived in migrant farm-worker camps, it was relatively easy to

assemble a comparison group who shared similar characteristics and experiences with the lay health advisors. In Huddersfield, by contrast, the communities are much more geographically and characteristically diverse, and finding a suitable comparison group would be a challenge. Because of this, changes in empowerment were assessed according to the perceptions of the PHEs themselves, rather than in comparison to an external group.

The other delimitation that was placed on the study is the fact that, rather than conducting a complete evaluation of PHEP, the study looked at only one aspect of PHEP. The Huddersfield NHS Trust will be conducting a complete evaluation of the programme, and this research is designed to highlight one aspect of the PHEs experiences that will not necessarily be captured by the evaluation process.

Areas for Future Research

This study reveals several areas for future research. The most obvious area would be to repeat the interviews at several points in time and use the results to increase the richness of the data and to paint a more complete picture of the experience of becoming a PHE.

As mentioned in the section on methodological issues, indicators used for empowerment may not be the most appropriate for this group. Therefore another area for future research is in developing empowerment indicators for PHEs.

In this study we see glimpses of the effect of the professional environment on the experience of participants. Such factors as organisational readiness, attitude of health professionals (e.g., nurses and doctors) towards paraprofessionals, and the nature and type of support provided by both the Peer Health Education Coordinator and other

members of the health promotion team may all have an effect on the development, confidence, and effectiveness of PHEs. This research could both demonstrate how to assess whether an organisation is ready for a team of community paraprofessionals and give clues as to how to optimise the work environment to ensure that PHEs are able to develop under the most favourable conditions.

This study did not measure the effectiveness of PHEs in their community. There are at least two areas for further study relating to this: first, the effectiveness of PHEs at both delivering health messages and stimulating change in their community; and second, relating these results to the PHEs' own perceptions of their effectiveness.

This study involved an Anglo-Canadian researcher and participants from four cultures: African-Caribbean, Indian-Sikh, Pakistani-Muslim, and Syrian. Although cultural complexities are the *raison d'être* of the PHEP, this study did not explore the cultural complexities involved in working as a PHE or the complexities in administering a multicultural programme. Both of these would be potential areas for future research.

The PHEP is built upon a participatory model. Equipped with tools, knowledge, and support, PHEs create health-promotion activities that are appropriate to their community. Therefore, the use of Participatory Action Research (PAR) would be a natural approach for future research within this group. PAR creates "knowledge that is relevant to a community's needs and interests" (Gibson, Gibson, & Macaulay, 2001, p. 1) and provides opportunities for reciprocal learning. Community members learn about health strategies, and academics and health professionals learn about the communities in which they are working and/or studying (Gibson, Cave, & Doering, 2002). In PAR, community members and researchers collaborate on all areas of the research process,

including defining the research goals and objectives, methods, strategy, dissemination, and other areas (Macaulay et al., 1999). Providing additional training to PHEs so that they can act, as research associates would be one way of involving the PHEs in a PAR approach. This method was used to study sociocultural issues related to tuberculosis treatment and prevention (Gibson et al., 2002).

Conclusion

Overall, with one outlier case, the journey of transformation from a lay natural helper to a paraprofessional lay health advisor is a positive one. Consistent with the literature, the training period helped to build knowledge and self-confidence; however, this was followed by a period of uncertainty when the PHEs were trying to define their role. Once finished the training period and working in the community, they found that although some areas of the Trust were supportive of the PHEs, some health professionals were not. Through perseverance, the PHEs defined their role and achieved success in the community. They have increased feelings of self-efficacy and are able to define their life goals in concrete terms. Although they can identify social and political structures in the community, the PHEs still focus mainly on individual-level interventions.

The ultimate goal of PHEP is to create an empowered community. Wallerstein and Bernstein (1994) define community empowerment as "an interactive process of change", where communities become more empowered as individuals within them increase their own levels of empowerment. The PHEP, in its first few months of operation, advanced part-way along this definition: in becoming lay health advisors, the PHEs have become more empowered. In turn, they are making efforts to empower other individuals in the community. Natural helpers have transformed into lay health advisors

with a degree of empowerment. The next step is to bring this transformation to the community level.

Capturing the journey of transformation from a lay natural helper to a paraprofessional lay health advisor is a challenge. The data-collection techniques and indicators deliver an important snapshot of the complete journey. This study, however, opens the door to future research in this area, including a follow-up on this group of PHEs and work on indicator development.

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APPENDIX A JOB DESCRIPTION OF PEER HEALTH EDUCATORS

Job Description

Directorate: Primary Care

Post: Peer Health Educator – Huddersfield SRB5 Area

Accountable to: Peer Health Development Worker

Base: Princess Royal Community Health Centre, with most work performed at community venues (but may be required to work elsewhere in the Trust according to the needs of the service)

Purpose of Post

Peer Health Educators will work with others in the community and in health setting to “help people help themselves” to lead a healthier lifestyle. Peer Health Educators will deliver health messages in creative ways and will act as an intermediate step between to community and health and human service professionals.

Peer Health Educators will have four main roles to play:

- Providing health information in culturally sensitive ways
- Helping to overcome cultural and communication barriers to health education
- Connecting people to resources that exist in the community
- Giving feedback to help services and professionals give culturally-appropriate services

Full training is provided for these posts, therefore prospective Peer Health Educators need to be willing to commit to at least two days per week training for 15-17 weeks, and then commit to a one-year, renewable contract of employment. You will be paid during your training. Most Peer Health Educators will work 14 hours per week, but a limited number of other contracts are available for fewer hours per week.

We are interested in employing a team of 10-15 Peer Health Educators in total.

Peer Health Educators will be required to work flexible hours. The hours of work will be further identified once the team of Peer Health Educators is in post.

KEY AREAS

To “help people to help themselves” to lead a healthy, happy lifestyle through participating in the following:

1. Working in Community
 - 1.1 Delivering health information in creative ways that make the information relevant to your community;

- 1.2 Facilitating health-related activities to people in your community. The activities might include the following:
 - Parenting stream:
 - i. Infant massage
 - ii. Breastfeeding support
 - Heart Health Stream
 - i. Cookery Groups
 - ii. Walking Clubs
- 1.3 To link people with other resources in the community that would be helpful to them, and to advocate to remove any barriers that might prevent someone from using a service.
- 1.4 To maximise the effectiveness of your work by using your own knowledge and networks, and by developing new links within the community.
- 1.5 To educate health and human service professionals about language and cultural differences that impact on patient care, service delivery, and attitudes of health professionals.
2. Team Working
 - 2.1 To work with the whole team of Peer Health Educators, and to work on your own as required.
3. Project Development
 - 3.1 To use your ideas and experiences to further develop the role of the Peer Health Educators and the ways that the Peer Health Educators work. This part of the job will be done in conjunction with the Peer Health Education Coordinator.
 - 3.2 To participate in the development of resource material (i.e. leaflets, articles, cassette tapes, and others) that are appropriate for your peer group. This part of the job will be done in conjunction with the Peer Health Education Coordinator.
4. Professional Development
 - 4.1 To attend all required training and professional development.
 - 4.2 To be aware of Trust Policies and Procedures and ensure that they are followed.
 - 4.3 To undertake such other duties and responsibilities of an equivalent nature, as may be determined by the postholder's supervisor from time to time, in consultation with the postholder.

TERMS AND CONDITIONS OF SERVICE

Salary Scale: 12,358 – 14, 991 (British Pounds) per annum, pro rata

Hours: 14 per week (with a limited number of contracts for less hours)

Annual Leave: 23 days per annum plus 3 days after 5 years service and 2 days after 10 years service, plus 8 bank/statutory holidays pro rata.

Pension Scheme: The post is superannuable under the NHS Pension Scheme with deductions being at 6% of gross salary.

APPENDIX B

INDIVIDUAL INTERVIEW PROTOCOL

Explanation of the interview: Hi _____. It's nice to see you again. I would like to ask you some questions about your background, your experiences as a Peer Health Educator, and your perceptions of the Peer Health Education Program. There are no "right" answers. I would like you to tell me your honest feelings. I will not ever use your name or identity in anything that I share with anyone else, so please feel free to share your feelings with me. I might be asking you questions that you think I already know the answer to. The reason that I am doing this is that I am only using information that we discuss during this interview for the study, and not anything that I think I might know about you from before. Our conversation today will remain private between us. I will tape record our conversation so that I can take fewer notes and pay closer attention to what you are saying. No one but me will hear the tape. The interview will take about an hour and a half or so. If you want to stop at any time, just say so, and we will stop the interview, or if you want to delete anything, let me know. Are you OK to proceed? Do you have any questions before we begin?

Number: _____

Date: _____

Time of interview: _____

1. First, I would like to know a little about YOU. Who you are, where you're from, what kinds of things are important to you. Tell me a little about yourself . . .
(critical identity)

Probes:

- Where were you born?
- Where did you grow up?
- Tell me about your family of origin.
- How do you define yourself racially?
- How much education do you have?
- Are you married? Do you have kids? Tell me about your family.
- Tell me about the kinds of values that are important to you.
- What are some of the things that make you who you are?
- What do you like to do when you are not working?
- When you think of "YOUR" community, what does that community look like? Generally, who is part of it, where do they live, and what are they like?

2. Tell me a little bit about why you applied to become a Peer Health Educator
(*initial motivations and expectations*)

Probes:

- How were you involved in your community before becoming a Peer Health Educator?
- When you applied to be a Peer Health Educator, what did you think a Peer Health Educator did?
- How did you first learn about the program?
- What did you expect from the Peer Health Education Program when you initially applied?

3. Tell me about your experiences in the PHE training program. (*reflections on the training program*)

Probes:

- How much of what you learned in training was new to you? Tell me about the new things that you learned.
- What was the most important thing that you learned in training? Why?
- What effect did the training program have on you personally?
- How much of what you learned in training do you use in your work?
- How much of what you learned in training do you use outside of your work?

4. When you started working as a Peer Health Educator, what did you think that the expectations of the Huddersfield NHS Trust were on you? (*initial motivations and expectations*)

- Were these expectations similar or different to your expectations?
- Can you describe these similarities/differences?

5. Do you or have you had contact with doctors, nurses, midwives, or health visitors as part of your work as a Peer Health Educator?

- If yes,
 - What kind of contact have you had/do you have?
 - With whom do you have/have you had contact?
 - Was the contact positive or negative?
 - How do you feel you are treated by these individuals in your role as a Peer Health Educators?
 - What do you think is their view of your role as a Peer Health Educator?
 - What do you suggest, if anything, to improve working with medical professionals?

6. How has being a Peer Health Educator impacted on your life? (*Personal perceptions of being a Peer Health Educator*)

Probe:

- Do you feel that you have changed while becoming a Peer Health Educator?
- Do you feel more in control of your life?
- Has your self-esteem increased?
- Has it affected the way you look at some things?
- Has it changed the way your family treats you?
- Has it changed the way your community sees you?
- What positive affects has participating in the program had on your life?
- What negative/(not so positive) affects has participating in the program had on your life?

7. Do you feel that you are able to influence people in the community in your role as a Peer Health Educator?

8. What are some of the most serious health problems that affect people in your community? (*empowerment related to knowledge*)

9. How are these problems the same or different from problems that other groups of people have? (*empowerment related to knowledge*)

10. What, if anything, can people do to keep themselves healthy? (*empowerment related to knowledge*)

11. Which of these things are people likely to do? What makes it possible for people to do these things? (*empowerment related to knowledge*)

12. What do you think is the factor that affects the health of people in your community the most? (*empowerment related to knowledge*)

13. How might you go about changing things that you don't like about your working or living conditions? (*empowerment related to knowledge*)

Probes:

- What kinds of things do you think you might be able to change?
- Can you give me an example of something that you have done to change things? Or a plan about how you would go about changing something specific?
- As a Peer Health Educator, do you think that your approach to changing someone would be different than someone who is not a Peer Health Educator?

14. Do you feel that there is cooperation among the team of Peer Health Educators?
- If yes, how much and in what way?
 - If no, why not?
 - How do you think that more networking could happen among the Peer Health Educators?

15. What would you like to be doing ten years from now? (*empowerment related to the degree to which PHEs can describe specific life goals in specific terms*)

Probes:

- What are your family related goals?
- What would you like to see your children doing ten years from now?
- What are your work or career related goals?
- Can you give me a specific example?
- Can you say more about that?
- What needs to happen in order to achieve your goal(s)?
- How do you intend to do that?
- Have your goals changed since becoming a Peer Health Educator?

Those are all of the questions that I wanted to ask you today. Do you have any questions for me? Thank you very much for agreeing to do this interview with me.

APPENDIX C INFORMATION LETTER

(On Letterhead)

DATE

Peer Health Education Program
Huddersfield NHS Trust
Health Promotion Unit
Princess Royal Community Health Centre
Greenhead Road
Huddersfield, UK
HD1 4EW

Dear Peer Health Educators:

I am writing you this letter to invite your participation in a research project. As the final requirement for my Masters degree, I would like to talk to you about some of your experiences as Peer Health Educators. This letter will explain what my research is about and will ask you if you would like to participate in this study. Your participation is purely voluntary. You do not have to participate in this study. If you decide that you would rather not participate, there will be no negative consequences. Also, you may withdraw from the study at any time.

If you have any questions that you would like to have answered about the research project, or if you have any comments or concerns, you can contact me by e-mail at genevieve_jones@hotmail.com. You can also contact me by telephone at +1-819-770-6356. Any conversations that we have will be kept between us. If you wish, you may also contact my supervisor, Maryanne Doherty. Her e-mail address is mdoherty@ualberta.ca. Her phone number is +1-780-492-2937.

The reason for sending you this information letter now is so that it can answer any questions that you may have. Also, it will give you time to consider if you want to participate in the research. I will be sending consent forms by mid-February. If you want to participate, you can sign a consent form then and hand it to Chris in a sealed envelope. I am the only person who will open that envelope.

Thank you in advance for reading the attached information letter.

Sincerely,

Genevieve Jones
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Information on This Research Project

Project Title: Becoming a Peer Health Educator: Case Studies.

Goal of the Research Project: Because the role of a Peer Health Educator is unique, getting used to your roles as a Peer Health Educator will also be unique. This study will explore the ways that Peer Health Educators adjust to their roles.

From other studies, we see that programs like the Peer Health Education Program can have effects on the people who work as Peer Health Educators. In this research, I plan to explore certain aspects of the effect on participation in the Huddersfield Peer Health Education Program on the Peer Health Educators. These aspects are: your initial motivations for joining the program, your thoughts on the training program, your feelings about the Peer Health Education Program and being a Peer Health Educator, and your experience of working with other health care professionals during your work.

Who is the researcher?: Genevieve Jones

How will information be gathered for this study? Information for this study will be gathered in three ways:

1. I would like to look at copies of the "Daily Reflections" that you filled out every day in training.
2. I would like to talk with you individually about your experiences in the program.

If I choose to participate, how long will it take? I would like to spend about one-and-a-half hours (1 ½ hours) talking with you by yourself (individual interview). After that, I may like to spend some additional time talking with you. After that, I may like to spend some additional time talking with you. That is, after transcribing and analysing the data, I may need to spend additional time with you if there are any issues that emerge which I need further information about from you. This would be up to one-and-a-half hours (1 ½ hours). The most amount of time that I will spend with you in total is three (3) hours. The interviews will be tape-recorded and then transcribed (written down word-for-word). When I get something written, I will ask you to check it to see if it is accurate.

When and where will the interviews take place? I will be in Huddersfield to do the interviews in March 2002. Before I come, I will make appointments for interviews. The interviews will take place in a private meeting room at the Princess Royal Community Health Centre.

Do I have to participate in this study? No! You can choose to participate in this study, or decide that you do not want to participate in this study. If you decide that you would rather not participate, there will be no negative effect on you. Participating or not participating will not affect your role as a Peer Health Educator.

What if I decide to participate and then change my mind? That is OK. You can decide at any time during the study that you no longer want to participate. You can also

choose not to answer a particular question at any time. If you withdraw from the study, none of your information will be used.

Who will see the information that is collected in this study? First of all, your name will never be attached to any of the information that you give me. My thesis supervisor, Maryanne, and I are the only people who will ever listen to the tapes of the interviews. Maryanne and I also the only people who will look at your journals for this study. When we look at the journals, I will remove your name so that we will not know whose journal we are reading. I will be the only person who transcribes the tapes. When I transcribe the tapes, your name, and any other name that you mention, will be replaced with codes. Before I write the thesis, you will have a chance to look at the results and give me your comments. After I receive your comments, the results will be written in my Masters thesis. In the future, some of the thesis might be published in a journal. No one person will ever be able to be identified from the results. A copy of the final thesis, and any publications that result from this study, will be sent to the Peer Health Education Program. Finally, I will never mention our conversations during the interviews outside the interview room.

A note about confidentiality: All information you provide will be held private, except when the law requires reporting (i.e. in the case of child abuse).

How long will my information be kept?: The information you provide will be kept for at least five years after the study is done. The information will be kept in a secure place (i.e. locked filing cabinet in my thesis supervisors' office). Your name or any other identifying information will not be attached to the information you gave. Your name will also never be used in any presentations or publications of the study results.

Will this information be used in the future (after this study)?: The information you give us may be looked at in the future. This would help us answer other study questions. If this happens, the ethics board will first look at the study. They will ensure the information is used ethically.

How will I be kept informed of the project?: If you decide to participate, I will communicate with you to arrange times for your interview. I will either contact you directly or through Chris Sutherland. If any changes are made to the research project, I will let you know of these changes by e-mail or telephone.

Are there any potential negative effects if I participate in this study? We don't anticipate that there will be any negative effects to this study. However, if you have any uncomfortable feelings that come up, either during or after the interviews, both Beverley Hayes and I will be available to talk with you if you would like to share these thoughts.

Who will know if I choose to participate?: Unless you choose to tell, I will never reveal who decides to participate and who decides not to participate in this study. Consent forms will be handed in to Chris in a sealed envelope which only I will open.

What do I do if I am concerned about this research?: If you are concerned about this study, you can talk to the following people:

1. Genevieve Jones
2. Chris Sutherland, Catherine Putz, or Judy Moorehouse (Huddersfield NHS Trust)
3. Beverly Haynes (Huddersfield NHS Trust)
4. The University of Alberta Ethics Committee. Contact Karen Turpin, Administrative Assistant. Her e-mail is Karen.Turpin@ualberta.ca. Her phone number is +1-780-492-0839.

APPENDIX D CONSENT FORM #1

This consent form will be given along with the information letter (Appendix C).

PLEASE DO THE FOLLOWING:

- **IF YOU WISH TO PARTICIPATE IN THE STUDY:**
PLEASE SIGN THE FORM, PLACE THE SIGNED FORM IN THE ENVELOPE PROVIDED, AND SEAL THE ENVELOPE. ON THE OUTSIDE OF THE ENVELOPE WRITE "FOR GENEVIEVE" ONLY – DO NOT MAKE ANY OTHER MARK ON THE ENVELOPE. RETURN THE ENVELOPE TO CHRIS.
- **IF YOU DO NOT WISH TO PARTICIPATE IN THE STUDY:**
PLEASE PLACE THE BLANK FORM (DO NOT FILL IN OR SIGN) IN THE ENVELOPE AND SEAL THE ENVELOPE. ON THE OUTSIDE OF THE ENVELOPE WRITE "FOR GENEVIEVE" ONLY – DO NOT MAKE ANY OTHER MARK ON THE ENVELOPE. RETURN THE ENVELOPE TO CHRIS.

Part 1: Researcher Information

Name of Principal Investigator: Genevieve Jones
Affiliation: Student, Centre for Health Promotion Studies, University of Alberta
Contact Information: c/o 2, 312 rue Notre Dame, Hull, Quebec, CANADA J8X 3V2
PHONE: (819) 770-6356
E-MAIL: genevieve_jones@hotmail.com

Name of Co-Investigator/Supervisor: Dr. Maryanne Doherty
Affiliation: Associate Professor, Faculty of Education, University of Alberta
Contact Information: Edmonton, Alberta, CANADA T6G 2M7
PHONE: (780) 492-2937
E-MAIL: Maryanne.Doherty@ualberta.ca

Part 2: Consent of Subject

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached information sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	☐	☐
Have you had an opportunity to ask questions and discuss the study?	☒	☐
Do you want your journals from the training program to be used as part of the study?	☒	☐
Do you want to participate in the interviews?	☐	☐
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect your care.	☐	☐
Has the issue of confidentiality been explained to you? Do you understand who will have access to your records/information?	☐	☐

Part 3: Signatures

This study was explained to me by: _____

Date: _____

I agree to take part in this study.

Signature of Research Participant: _____

Printed Name: _____

Witness (if available): _____

Printed Name: _____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Researcher: _____

Printed Name: _____

*** A copy of this consent form must be given to the subject.**

APPENDIX E
CONSENT FORM #2

Consent Form #2 will be read aloud before individual interview. Consent of participant will be recorded on tape.

Explanation of the interview: Hi _____. I would like to ask you some questions about your background, your experiences as a Peer Health Educator, and your perceptions of the Peer Health Education Program. There are no "right" answers. I would like you to tell me your honest feelings. I will not ever use your name or identity in anything that I share with anyone else, so please feel free to share your feelings with me. I might be asking you questions that you think I already know the answer to. The reason that I am doing this is that I am only using information that we discuss during this interview for the study, and not anything that I think I might know about you from before. Our conversation today will remain private between us. I will tape record our conversation so that I can take fewer notes and pay closer attention to what you are saying. No one but me will hear the tape. The interview will take about an hour and a half or so. If you want to stop at any time, just say so, and we will stop the interview. Are you OK to proceed? Do you have any questions before we begin?

APPENDIX F
DAILY REFLECTIONS SHEET

(Given during the training program)

Daily Reflections on Peer Health Education Training

Feel free to use additional sheets as necessary

Name: _____

Date: _____

Reflections on content (what did I learn, what was new information, what was review information):

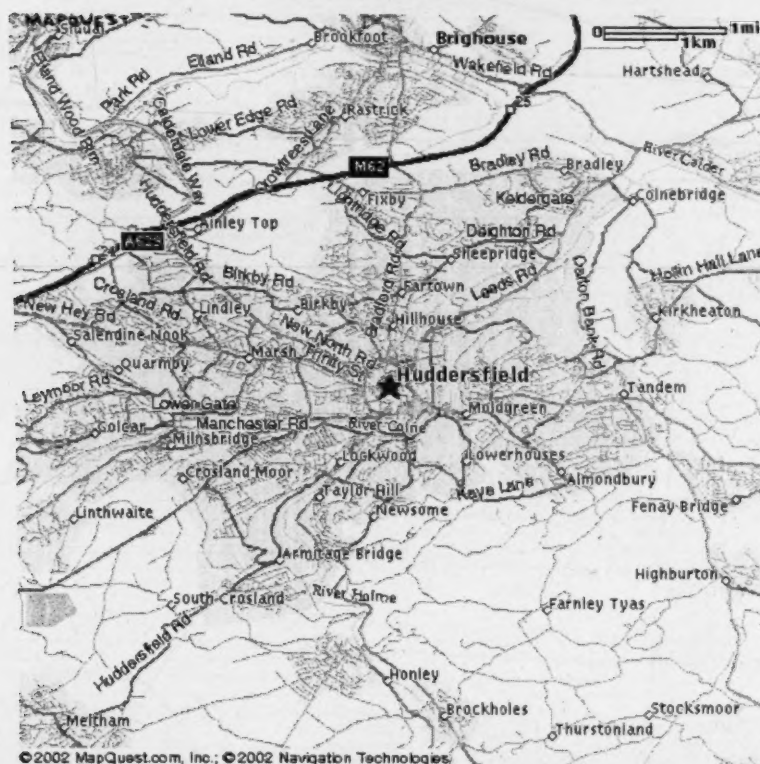
How do I feel about today's training content (does it make me feel happy, angry, confused, inspired, bored, etc):

What links do I see between today's content and other information (other training content, other information I know):

What relevance does today's content have with the role of the Peer Health Educator?

Other thoughts:

APPENDIX G MAPS OF HUDDERSFIELD AND AREA



Huddersfield, West Yorkshire, United Kingdom. Areas included in SRB5 funding are: Deighton, Brackenhall, Riddings, Birkby, Fartown, Paddock, Springwood, Crosland Moor, Thornton Lodge, Walpole, Milnsbridge, Newsome, Primrose Hill, Ashenhurst, and Lowerhouses.

